KENTUCKY & OHIO PART A

Medicare Bulletin

Jurisdiction 15

Reaching Out to the Medicare Community

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Medicare Bulletin

Jurisdiction 15

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General Information

2014 Provider Contact Center (PCC) Training and Holiday Closure Schedule

Medicare is a continuously changing program, and it is important that we provide correct and accurate answers to your questions. To better serve the provider community, the Centers for Medicare & Medicaid Services (CMS) allows the provider contact centers the opportunity to offer training to our customer service representatives (CSRs). The CGS Part A PCC (**1.866.590.6703**) will continue to close up to eight hours per month for CSR training and staff development. The Interactive Voice Response (IVR) unit will be available during these scheduled training sessions for automated customer service transactions.

Listed below are the training closure dates and time for April:

Date	PCC/Office Closed
April 3, 10, 17, and 24, 2014	PCC Closed 2:30 p.m. to 4:30 p.m. ET

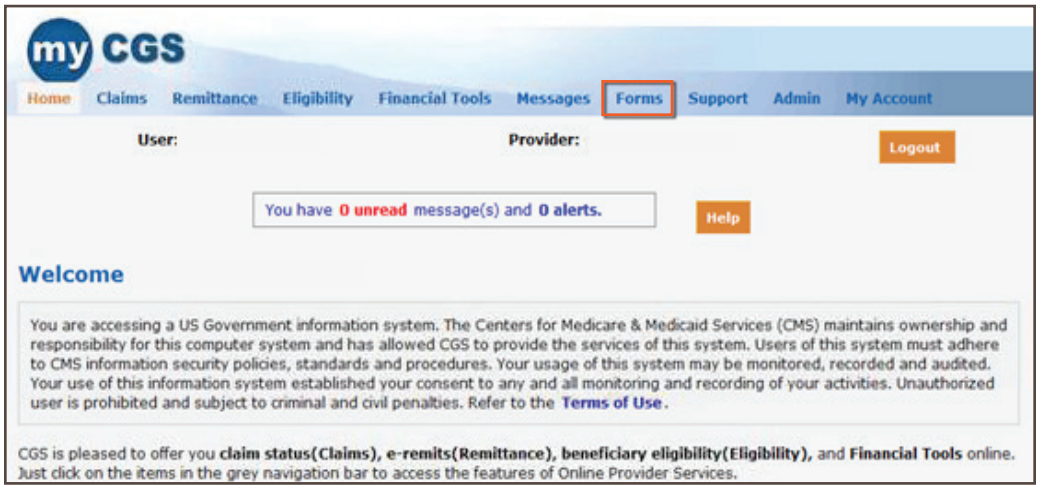
For your reference, access the **"Kentucky/Ohio Part A 2014 Holiday/Training Closure Schedule"** at https://www.cgsmedicare.com/parta/help/holiday_schedule.pdf for a complete list of PCC closures.

General Information

Introducing the myCGS Web Portal: Submitting Redeterminations through Forms Tab

This article is the third in a series of articles previously published in the *CGS Medicare Bulletin* to introduce the myCGS Web portal to all providers that submit claims to CGS.

The information below provides a general overview of the "Forms" tab in myCGS, which allows CGS providers to submit redetermination requests, the first appeal level, and monitor the status of these requests, using the myCGS Web portal.



What is the "Forms" tab in myCGS?

The "Forms" tab in myCGS allows users the ability to submit a redetermination request (1st appeal level) using the myCGS portal. Additional features via the Forms tab will be available in the near future.

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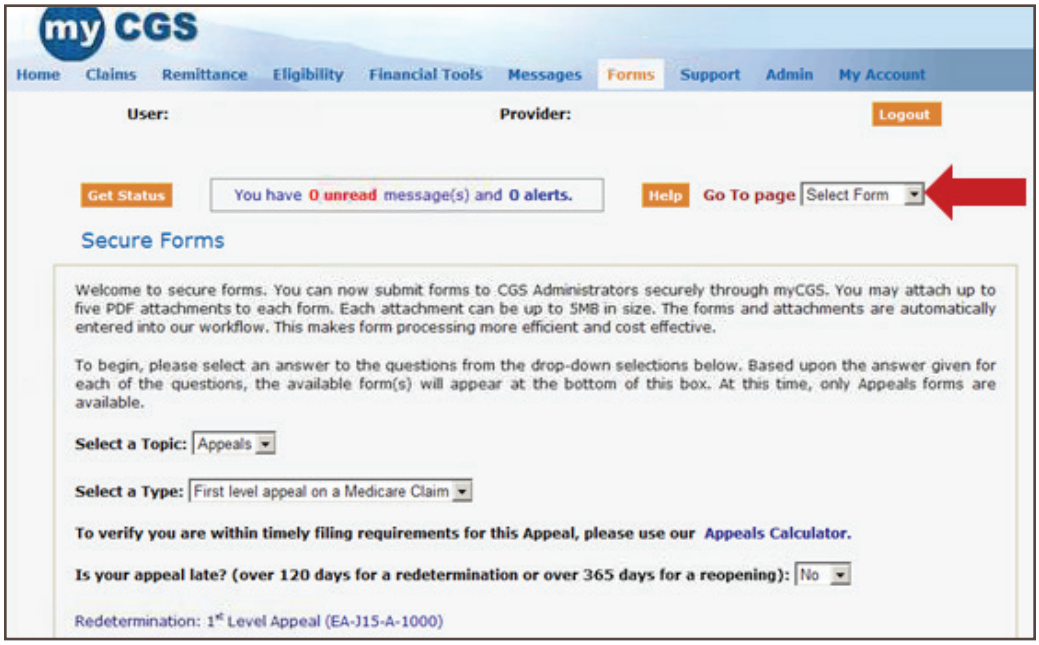
What do I need to know about using the "Forms" tab?

Only those myCGS users who have been assigned rights by their Provider Administrator will have access to the "Forms" tab. If you do not have access to the "Forms" tab, but believe you should, talk with the myCGS Provider Administrator for your agency/organization, and they can update your security.

How do I use the "Forms" tab to submit a redetermination request?

To submit a redetermination request, click on the "Forms" tab to access the Secure Forms page. In the "Go To page" field, select the "Secure Forms" option.



Currently, the only level of appeal that can be submitted via the myCGS portal is the first level of appeal, the redetermination. To determine if your appeal request is still timely, click on the "Appeals Calculator" link. If your appeal is untimely, you cannot submit your redetermination request via the myCGS portal.

Click on the "Redetermination: 1st Level Appeal" link to access the online Redetermination Form.

What information do I need to submit a redetermination request using myCGS?

The *myCGS Redetermination Form* is separated into sections: Beneficiary Information, Provider Information, and Attachments. Basic information, such as the beneficiary's claim number (HICN), dates of service being appealed, the Document Control Number (DCN) of the claim being appealed, and an explanation about why you are appealing the claim. It is also important to indicate whether your appeal request is related to an overpayment, such as the Comprehensive Error Rate Testing (CERT) program, a recovery audit (RA) findings, or a Zone Program Integrity Contractor (ZPIC) review. Fields that contain a red asterisk indicate that information is required.

myCGS also allows documentation supporting the appeal request to be attached directly to the redetermination request. This eliminates the need to copy and mail documentation with your appeal request. myCGS will accommodate up to 5 attachments, of 5 MB each, which should accommodate all medical documentation required for a patient's claim. Attachments must be in a PDF format, and at least one attachment is required.

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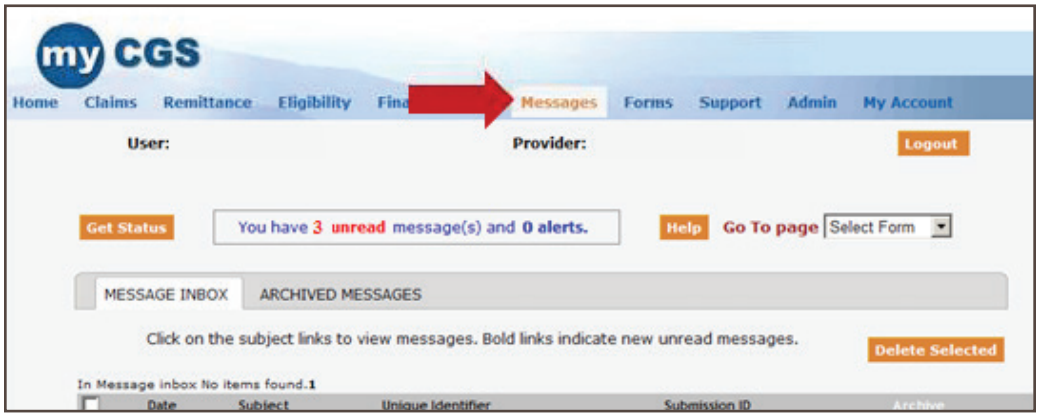
How do I know if my Redetermination request was successfully received?

Once all required information is entered, simply click the "Submit" button to submit your redetermination request to CGS. You will receive a message in your myCGS inbox. You can access the message by either clicking on the Messages tab, or clicking the link displayed in the Message bar.



myCGS will confirm receipt of your redetermination request by indicating "Secure Form Received." Once a tracking number has been assigned to your redetermination request, myCGS will show "Secure Form Confirmation" along with the Submission ID number so you can continue to monitor your redetermination request.

For more information about the "Forms" tab, and submitting redeterminations using myCGS, go to Chapter 6: Messaging/Forms Tab of the *myCGS User Manual*, http://www.cgsmedicare.com/mycgs/manual.html, and select the appropriate link for your line of business (Part B or Home Health & Hospice).

General Information

MLN Connects™ Provider e-News

The MLN Connects™ Provider e-News contains a week's worth of Medicare-related messages issued by the Centers of Medicare & Medicaid Services (CMS). These messages ensure planned, coordinated messages are delivered timely about Medicare-related topics. The following provides access to the weekly messages. Please share with appropriate staff. If you wish to receive the ListServ directly from CMS, please contact CMS at LearnResource-L@cms.hhs.gov.

- **February 20, 2014** - http://go.usa.gov/Bfxh
- **February 27, 2014** - http://go.usa.gov/BJwz
- **March 6, 2014** - http://go.usa.gov/KgZY
- **March 13, 2014** - http://go.usa.gov/K83W

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MM8442: Update to Pub 100-04, Claims Processing Manual, Chapter One

The Centers for Medicare & Medicaid Services (CMS) has issued the following ***Medicare Learning Network® (MLN) Matters*** article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2014-MLN-Matters-Articles.html

MLN Matters® Number: MM8442
Related CR Release Date: February 7, 2014
Related CR Transmittal #: R2876CP
Related Change Request (CR) #: CR 8442
Effective Date: March 7, 2014
Implementation Date: March 7, 2014

Provider Types Affected

This MLN Matters® article is intended for individual providers or chains submitting claims to Part A Medicare administrative contractors (MAC) for services to Medicare beneficiaries.

What You Need To Know

CR 8442 removes amends the Medicare Claims Processing Manual to show that provider chains and individual providers are no longer permitted to select the fiscal intermediary of their choice.

Background

CR 8442, from which this article is taken removes certain sections from the Medicare Claims Processing Manual because they contain policy based on the legacy environment during which chains and individual providers were permitted to select the fiscal intermediary of their choice.

Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Public Law 108–173 (which you can find at http://www.gpo.gov/fdsys/pkg/PLAW-108publ173/pdf/PLAW-108publ173.pdf on the internet), amended Title XVIII of the Social Security Act (the Act) to repeal its provider nomination provision, and replaced it with the geographic assignment rule. This means that a chain, or an individual provider, can no longer select the fiscal intermediary (FI) or MAC of its choice, and you should be aware that your MAC will no longer accept your requests for "change of intermediary."

Rather, an individual provider will be assigned to the MAC that covers the state in which the provider is located; and a chain that meets the criteria set forth at 42 CFR 421.404 may contact CMS and ask to have all eligible, downstream providers assigned to the MAC that covers the state in which the chain's home office is located. (A chain home office wishing to contact CMS to request "qualified chain" status may send an email to Provider_MAC_Assignment_Inquiry@cms.hhs.gov.)

Additional Information

The official instruction, CR 8442 issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2876CP.pdf on the CMS website.

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at **1.866.590.6703** and choose Option 1.

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MM8506: Pub 100-03, Chapter 1, Language-only Update

The Centers for Medicare & Medicaid Services (CMS) has issued the following ***Medicare Learning Network® (MLN) Matters*** article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2014-MLN-Matters-Articles.html

MLN Matters® Number: MM8506
Related CR Release Date: February 5, 2014
Related CR Transmittal #: R159NCD
Related Change Request (CR) #: CR 8506
Effective Date: October 1, 2014
Implementation Date: October 1, 2014

Provider Types Affected

This MLN Matters® article is intended for physicians, providers, and suppliers submitting claims to A/B Medicare administrative contractors (A/B MACs), hospice and home health (HH&H MACs), and durable medical equipment MACs (DME MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

CMS issued CR 8506 as an informational alert to providers that language-only changes—updates to the *Medicare National Coverage Determinations (NCD) Manual*, Pub 100-03—were made.

The changes were made to comply with:

1. Conversion from ICD-9 to ICD-10;
2. Conversion from ASC X12 Version 4010 to Version 5010;
3. Conversion of former contractor types to MACs; and,
4. Other miscellaneous editorial and formatting updates provided for better clarity, correctness, and consistency.

Note: The edits made to the NCD Manual are technical/editorial only and in no way alter existing NCD policies.

Background

These edits to Pub. 100-03 are part of a CMS-wide initiative to update its manuals and bring them in line with recently released instructions regarding the above-noted subject matter.

Additional Information

The official instruction, CR 8506, issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R159NCD.pdf on the CMS website.

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at **1.866.590.6703** and choose Option 1.

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MM8582 (Revised): Claim Status Category and Claim Status Codes Update

The Centers for Medicare & Medicaid Services (CMS) has issued a revision to the following ***Medicare Learning Network® (MLN) Matters*** article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2014-MLN-Matters-Articles.html

MLN Matters® Number: MM8582 *Revised*
Related CR Release Date: February 24, 2014
Related CR Transmittal #: R2884CP
Related Change Request (CR) #: CR 8582
Effective Date: April 1, 2014
Implementation Date: April 7, 2014

Note: This article was revised on February 27, 2014, to reflect an updated Change Request (CR). The CR corrects the date when the Claim Status Category Codes and Claim Status Codes will be posted, which is March 1, 2014. All other information remains the same.

Provider Types Affected

This MLN Matters® article is intended for physicians, other providers, and suppliers submitting claims to Medicare administrative contractors (MACs), including durable medical equipment Medicare administrative contractors (DME MACs) and home health & hospice MACs, for services to Medicare beneficiaries.

Provider Action Needed

This article is based on CR 8582 which informs Medicare contractors about the changes to Claim Status Category Codes and Claim Status Codes. Make sure that your billing personnel are aware of these changes.

Background

The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only Claim Status Category Codes and Claim Status Codes approved by the national Code Maintenance Committee in the X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for national use (e.g. previous HIPAA named versions included 004010X093A1). These codes explain the status of submitted claim(s). Proprietary codes may not be used in the X12 276/277 to report claim status. The National Code Maintenance Committee meets at the beginning of each X12 trimester meeting (February, June, and October) and makes decisions about additions, modifications, and retirement of existing codes. The codes sets are available at http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/ and http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/ on the Internet.

All code changes approved during the January 2014 committee meeting shall be posted on these sites on or about March 1, 2014. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

These code changes are to be used in the editing of all X12 276 transactions processed on or after the date of implementation and are to be reflected in X12 277 transactions issued on and after the date of implementation of CR 8582.

Additional Information

The official instruction, CR 8582 issued to your MAC regarding this change may be viewed at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2884CP.pdf on the CMS website.

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General Information

MM8611: Healthcare Provider Taxonomy Codes (HPTC) Update, April 2014

The Centers for Medicare & Medicaid Services (CMS) has issued the following ***Medicare Learning Network® (MLN) Matters*** article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2014-MLN-Matters-Articles.html

MLN Matters® Number: MM8611
Related CR Release Date: February 28, 2014
Related CR Transmittal #: R2888CP

Related Change Request (CR) #: CR 8611
Effective Date: April 1, 2014
Implementation Date: July 7, 2014 (Contractors with the capability to do so will implement April 1, 2014)

Provider Types Affected

This MLN Matters® article is intended for physicians, other providers, and suppliers submitting claims to Medicare claims administration contractors (fiscal intermediaries (FIs), carriers, A/B Medicare administrative contractors (A/B MACs), regional home health intermediaries (RHHIs), home health and hospices MACs (HHH MACs), and durable medical equipment MACs (DME MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

CR 8611, from which this article is taken, instructs Medicare contractors to obtain the most recent HPTC set and use it to update their internal HPTC tables and/or reference files.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that covered entities use the standards adopted under this law for electronically transmitting certain health care transactions, including health care claims. The standards include implementation guides which dictate when and how data must be sent, including specifying the code sets which must be used.

Both the current Accredited Standards Committee (ASC) X-12 837 institutional and professional Technical Report Type 3 (TR3s) require that the National Uniform Claim Committee (NUCC) HPTC set be used to identify provider specialty information on a health care claim. However, the standards do not mandate the reporting of provider specialty information via a HPTC be on every claim, nor for every provider to be identified by specialty. The standard implementation guides state that this information is:

- "Required when the payer's adjudication is known to be impacted by the provider taxonomy code;" and
- "If not required by this implementation guide, do not send."

Note: Medicare does not use HPTCs to adjudicate its claims and would not expect to see these codes on a Medicare claim. However, currently, it validates any HPTC that a provider happens to supply against the NUCC HPTC set.

The Transactions and Code Sets Final Rule, published on August 17, 2000, establishes that the maintainer of the code set determines its effective date. See http://aspe.hhs.gov/admnsimp/final/txfin00.htm on the Internet. This rule also mandates that covered

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entities must use the nonmedical data code set specified in the standard implementation guide that is valid at the time the transaction is initiated. For implementation purposes, Medicare generally uses the date the transaction is received for validating a particular nonmedical data code set required in a standard transaction.

The HTPC set is maintained by the NUCC for standardized classification of health care providers, and the NUCC updates the code set twice a year with changes effective April 1 and October 1. The HPTC set is available for view or for download from the Washington Publishing Company (WPC) at http://www.wpc-edi.com/codes on the Internet

CR 8611 implements the NUCC HPTC code set that is effective on April 1, 2014, and instructs Medicare contractors to obtain the most recent HPTC set and use it to update their internal HPTC tables and/or reference files.

When reviewing the HPTC set online, revisions made since the last release can be identified by the color code:

- New items are green;
- Modified items are orange; and
- Inactive items are red.

Additional Information

The official instruction, CR 8611 issued to your carriers, FIs, A/B MACs, RHHIs, HHH MACs, and DME MACs, regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2888CP.pdf on the CMS website.

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at **1.866.590.6703** and choose Option 1.

General Information

News Flash Messages from the Centers for Medicare & Medicaid Services (CMS)

- Looking for the latest new and revised MLN Matters® articles? Subscribe to the MLN Matters® electronic mailing list! For more information about MLN Matters® and how to register for this service, go to http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/What_Is_MLNMatters.pdf and start receiving updates immediately!
- **Products from the Medicare Learning Network® (MLN)**
  - NEW "Information on the National Physician Payment Transparency Program: Open Payments," Podcast, ICN 908961, downloadable only at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Multimedia-Items/ICN908961-Podcast.html
  - NEW "Vaccine Payments Under Medicare Part D" Fact Sheet, ICN 908764, downloadable and hard copy at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Vaccines-Part-D-Factsheet-ICN908764.pdf
  - NEW "Hospice Related Services – Part B" Podcast, ICN 908995, downloadable only at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Multimedia-Items/ICN908995-podcast.html

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- REVISED "Contractor Entities At A Glance: Who May Contact You About Specific Centers for Medicare & Medicaid Services (CMS) Activities" Educational Tool, ICN 906983, downloadable at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ContractorEntityGuide_ICN906983.pdf
- Revised "Medical Privacy of Protected Health Information," Fact Sheet, ICN 006942, Downloadable only at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/SE0726FactSheet.pdf
- REVISED "Quick Reference Information: Medicare Immunization Billing" Educational Tool, ICN 006799, downloadable at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/qr_immun_bill.pdf
- REVISED "General Equivalence Mappings Frequently Asked Questions," Booklet, ICN 901743, hard copy only at http://www.cms.gov/Medicare/Coding/ICD10/Downloads/GEMs-CrosswalksBasicFAQ.pdf
- NEW "Medicare Quarterly Provider Compliance Newsletter [Volume 4, Issue 2]" Educational Tool, ICN 908994, downloadable at http://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedQtrlyComp-Newsletter-ICN908994.pdf
- RELEASED "Transitional Care Management Services," Fact Sheet, ICN 908628, Hard Copy only at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf
- Revised "Inpatient Rehabilitation Facility Prospective Payment System" Fact Sheet, ICN 006847, downloadable at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/InpatRehabPaymtfctsht09-508.pdf
- Revised "End-Stage Renal Disease Prospective Payment System" Fact Sheet (ICN 905143) downloadable format at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/End-Stage_Renal_Disease_Prospective_Payment_System_ICN905143.pdf
- REVISED "Medicare Enrollment and Claim Submission Guidelines", Booklet, ICN 906764, Downloadable and hard copy at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedicareClaimSubmissionGuidelines-ICN906764.pdf

- Want to stay connected about the latest new and revised Medicare Learning Network® (MLN) products and services? Subscribe to the MLN Educational Products electronic mailing list! For more information about the MLN and how to register for this service, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads//MLNProducts_ListServ.pdf and start receiving updates immediately!
- Generally, Medicare Part B covers one flu vaccination and its administration per flu season for beneficiaries without co-pay or deductible. Now is the perfect time to vaccinate beneficiaries. Health care providers are encouraged to get a flu vaccine to help protect themselves from the flu and to keep from spreading it to their family, co-workers, and patients. Note: The flu vaccine is not a Part D-covered drug. For more information, visit:
  - MLN Matters® Article #MM8433, "Influenza Vaccine Payment Allowances - Annual Update for 2013-2014 Season" - http://www.cms.gov/Outreach-and-

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Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8433.pdf

- MLN Matters® Article #SE1336, "2013-2014 Influenza (Flu) Resources for Health Care Professionals" - http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1336.pdf
- HealthMap Vaccine Finder (http://vaccine.healthmap.org/) - a free, online service where users can search for locations offering flu and other adult vaccines. While some providers may offer flu vaccines, those that don't can help their patients locate flu vaccines within their local community.
- Free Resources (http://www.cdc.gov/flu/freeresources/), can be downloaded from the CDC website including prescription-style tear-pads that allow you to give a customized flu shot reminder to patients at high-risk for complications from the flu. On the CDC order form, under "Programs", select "Immunizations and Vaccines (Influenza/Flu)" for a list of flu related resources.

- Are you ready to transition to ICD-10 on October 1, 2014? In this MLN Connects™ video at http://www.youtube.com/watch?v=kCV6aFIA-Sc&feature=youtu.be on ICD-10 Coding Basics, Sue Bowman from the American Health Information Management Association (AHIMA) provides a basic introduction to ICD-10 coding, including:
  - Similarities and differences;
  - ICD-10 code structure; and
  - Coding process and examples.

  To receive notification of upcoming MLN Connects videos and calls and the latest Medicare program information on ICD-10, subscribe to the weekly MLN Connects™ Provider eNews at https://public-dc2.govdelivery.com/accounts/USCMS/subscriber/new?pop=t&topic_id=USCMS_7819 .
- **MLN Matters® Articles Index:** Have you ever tried to search MLN Matters® articles for information regarding a certain issue, but you did not know what year it was published? To assist you next time in your search, try the CMS article indexes that are published at http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/MLNMattersArticles/ on the CMS website. These indexes resemble the index in the back of a book and contain keywords found in the articles, including HCPCS codes and modifiers. These are published every month. Just search on a keyword(s) and you will find articles that contained those word(s). Then just click on one of the related article numbers and it will open that document. Give it a try.

General Information

Quarterly Provider Update

The Quarterly Provider Update is a comprehensive resource published by the Centers for Medicare & Medicaid Services (CMS) on the first business day of each quarter. It is a listing of all nonregulatory changes to Medicare including transmittals, manual changes, and any other instructions that could affect providers. Regulations and instructions published in the previous quarter are also included in the update. The purpose of the Quarterly Provider Update is to:

- Inform providers about new developments in the Medicare program;
- Assist providers in understanding CMS programs and complying with Medicare regulations and instructions;

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- Ensure that providers have time to react and prepare for new requirements;Announce new or changing Medicare requirements on a predictable schedule; and
- Communicate the specific days that CMS business will be published in the Federal Register.

To receive notification when regulations and program instructions are added throughout the quarter, go to https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/CMS-Quarterly-Provider-Updates-Email-Updates.html to sign up for the Quarterly Provider Update (electronic mailing list).

We encourage you to bookmark the Quarterly Provider Update website at https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/index.html and visit it often for this valuable information.

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at **1.866.590.6703** and choose Option 1.

General Information

SE1402: Updated Mobile Applications (Apps) for Open Payments

The Centers for Medicare & Medicaid Services (CMS) has issued the following ***Special Edition Medicare Learning Network® (MLN) Matters*** article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2014-MLN-Matters-Articles.html

MLN Matters® Number: SE1402
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected

This MLN Matters® Special Edition (SE) is intended for physicians, providers and suppliers submitting claims to Medicare administrative contractors (MACs), for services to Medicare beneficiaries.

What You Need to Know

CMS is issuing this article to alert the provider community of updates to the mobile applications (apps), *Open Payments Mobile for Industry* and *Open Payments Mobile for Physicians*, implemented as a result of user feedback to CMS. See the "Background" and "Key Points" sections of this article for details.

Also, a part of SE1402 is new technical documentation: "The Open Payments QR Code Reader How-To Guide." Included are the technical instructions for creating or importing contact information using a QR code reader and generating a QR code to transfer profile or payment information to other user devices.

Background

In July 2013, CMS released two mobile apps: *Open Payments Mobile for Industry* and *Open Payments Mobile for Physicians*. Below are enhancements to the original Open Payments mobile apps. The changes to the apps include the following:

- Streamlining the menu on the Welcome screen;
- Adding the ability to export **all** profile data associated with a payment into CSV format; and

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- Developing a new function to view reports of payments in bar and pie charts.

The apps are intended to support reporting under the Open Payments program. For more details refer to: http://www.cms.gov/Regulations-and-Guidance/Legislation/National-Physician-Payment-Transparency-Program/index.html on the CMS website. For help with the apps contact the CMS helpdesk at OpenPayments@cms.hhs.gov.

Key Points of SE1402

If you already downloaded the apps, you will need to run an update to take advantage of the new app functionality. To do so, visit either the Google Play™ app store or iOSApple™ app store, look for your available updates, and select the Open Payments apps to download the updates. If you have not yet downloaded the apps, search for Open Payments in the applicable app store and you'll be prompted to download the newly updated versions.

In response to user feedback, the table below describes the enhancements made to the apps since their initial launch in July 2013. All changes are intuitive and will add elements of ease expected by app users.

Enhancement Topic	Details – What It Does
Changes that Apply to Both Apps *(Open Payments Mobile for Industry and Open Payments Mobile for Physicians)*	
Streamlined "Welcome" screen options	• A number of infrequently used menu options (e.g., "Program Information" and "Change Password") moved from the "Welcome" screen and now appear in a hidden menu. • To access the menu, swipe to the right at the "Welcome" screen.
Reports/Statistics	• A new "Reports/Statistics" button, accessible on the "Welcome" screen, allows the user to create a chart (bar and pie), showing their transfer of value data sorted by physician (within Open Payments Mobile for Industry) or vendor (within Open Payments Mobile for Physicians). • This new chart creation capability will streamline data review.
CSV exporting	• When payment data is exported via CSV format, all profile data for the associated vendor/physician is included in the CSV file (including address, phone number, etc.). • The prior app version included only vendor/physician name in the CSV file. This enhancement will simplify the data review process.
Streamlined "Add Payment" process	• The steps to "Add Payment" are streamlined to allow the user to enter contact information for the vendor or physician, while staying within the "Add Payment" menu. • The prior app version required the user to first enter contact information for the vendor or physician separately, and then go to the "Add Payment" menu.
Easy payment duplication	• A new button available on the "View Payment" screen allows payment data to be easily duplicated, in case a physician or vendor has multiple occurrences of the same payment. • The only data field that needs to be re-entered is the date.
Vendors/Physicians sorted alphabetically	• In "Manage Vendors/Physicians," vendors or physicians are now listed alphabetically. • The prior app version listed vendors and physicians in the order in which they were entered.
Email/print QR code added	• A "Share" button is available to email or print a QR code that is generated within the app, for sharing at a later time.
Payment QR code warning added	• After a payment QR code is scanned, a red warning message appears to remind the user to manually add the vendor or physician name to the payment data conveyed in the QR code.
Additional data elements added in "Add Payment" > "Travel & Lodging"	• When nature of payment in "Add Payment" is "Travel & Lodging," the following additional data elements can be entered: city, state, and country of travel (note that these new data elements are required for reporting purposes; but remember, the apps are not used for reporting data, only for tracking it).
Tablet support	• Both apps are optimized for viewing on tablet devices.

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Enhancement Topic	Details – What It Does
Changes that Apply to Just One App *Open Payments Mobile for Physicians*	
"Manage Companies" added	• Within "Manage Vendors", a new data field allows users to assign vendors to companies when entering new vendor information. • Company information is needed for the "Reports/Statistics" functionality to illustrate all payments by company name.

The updated Frequently Asked Questions at http://www.cms.gov/Regulations-and-Guidance/Legislation/National-Physician-Payment-Transparency-Program/Downloads/Mobile-App-FAQs-%5bAugust-2013%5d.pdf about the mobile apps contain all the details about these enhancements (link to the document above, or visit the "Apps for Tracking Assistance" page on the Open Payments website).

QR Code Technical Guide Available for Apps: Also now available to support use of the Open Payments apps is a how-to-guide that explains the technical details associated with how to create Quick Response (QR) codes usable in the apps. "The Open Payments QR Code Reader How-To Guide" includes detailed, highly technical instructions for creating or importing contact information using a QR code reader, and generating a QR code to transfer profile or payment information to other user's devices.

Additional Information

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at **1.866.590.6703** and choose **Option 1**.

To review "The Open Payments Mobile Application Quick Response (QR) Code Reader Documentation: A How-To Guide to Create Java Script Object Notation (JSON) QR Code" referenced in this SE1402, see http://www.cms.gov/Regulations-and-Guidance/Legislation/National-Physician-Payment-Transparency-Program/Downloads/Open-Payments-QR-Code-Reader-How-To-Guide-%5bDecember-2013%5d.pdf on the CMS website.

To review the series of SE articles leading up to SE1402 see the following:

1. MLN Matters® SE1303 "Information on the National Physician Payment Transparency Program: Open Payments," is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1303.pdf on the CMS website.
2. MLN Matters® SE1329 "Mobile Apps for the Open Payments program (Physician Payments Sunshine Act)" is available at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1329.pdf on the CMS website.
3. MLN Matters® SE1330 "Open Payments: An Overview for Physicians and Teaching Hospitals" may be found at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1330.pdf on the CMS website.

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Common Working File Information

MM8456 (Revised): Modifying the Daily Common Working File (CWF) to Medicare Beneficiary Database (MBD) File to Include Diagnosis Codes on the Health Insurance Portability and Accountability Act Eligibility Transaction System (HETS) 270/271 Transactions

The Centers for Medicare & Medicaid Services (CMS) has issued the following ***Medicare Learning Network® (MLN) Matters*** article on February 11, 2014. A revision to this article was then issued on March 7, 2014. The following reflects the revised article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2014-MLN-Matters-Articles.html

MLN Matters® Number: MM8456 *Revised*
Related CR Release Date: March 6, 2014
Related CR Transmittal #: R1356OTN
Related Change Request (CR) #: CR 8456
Effective Date: October 1, 2014
Implementation Date: October 6, 2014

Note: This article was revised on March 7, 2014, to reflect a revised Change Request (CR). The revise CR changes the effective and implementation dates. All other information remains the same.

Provider Types Affected

This MLN Matters® article is intended for physicians, providers, and suppliers submitting claims to Medicare administrative contractors (MACs), including home health & hospice (HH&H) MACs and durable medical equipment Medicare administrative contractors (DME MACs) for services to Medicare beneficiaries.

Provider Action Needed

This article is based on CR 8456, which informs Medicare contractors about changes to the Medicare Beneficiary Database (MBD) File to include Diagnosis Codes on the Health Insurance Portability and Accountability Act Eligibility Transaction System (HETS) 270/271 transactions.

The HETS 271 response transaction will include as much Medicare Secondary Payer (MSP) information as possible to assist providers, physicians, and suppliers to identify which diagnosis codes are relevant to given MSP no-fault, liability, and workers' compensation cases. The diagnosis codes that the provider community will access via the HETS 270/271 process will assist providers, physicians, and other suppliers to better determine when Medicare is the secondary payer in association with their patients' current liability, no fault, or workers' compensation incidents that may prompt beneficiaries to seek medical services. Please ensure that your billing staffs are aware of these changes.

Background

The HETS 270/271 process is used by providers, physicians, and other suppliers to receive individual beneficiary eligibility information under the Medicare program, including information found on the CWF MSP auxiliary file. Although most MSP information from the MSP record is currently included on the HETS 271 response transaction, International Classification of Diseases (ICD), Clinical Modification (CM), diagnosis codes are not included. CMS believes it would be beneficial for CWF to include ICD-CM diagnosis codes, as derived from MSP no-fault, liability, and workers'

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compensation MSP auxiliary records, on the interface file that it sends to MBD. Through a separate Medicare Advantage Prescription Drug CR, CMS will ensure that the MBD table information that is exchanged with HETS will be modified to include ICD diagnosis codes. Thereafter, the diagnosis codes will be included in the HETS 271 response transaction that CMS makes available to providers, physicians, and suppliers.

Since the HETS 271 response transaction can only accommodate up to 8 diagnosis codes, CR 8456 instructs CWF to send up to 25 iterations of diagnosis codes associated with MSP no-fault, liability, and workers' compensation records for inclusion on the HETS 271 response transaction.

Additional Information

The official instruction, CR 8456 issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1356OTN.pdf on the CMS website.

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at **1.866.590.6703** and choose Option 1.

Common Working File Information

MM8620: CWF Editing for Vaccines Furnished at Hospice - Correction

The Centers for Medicare & Medicaid Services (CMS) has issued the following ***Medicare Learning Network® (MLN) Matters*** article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2014-MLN-Matters-Articles.html

MLN Matters® Number: MM8620
Related CR Release Date: February 6, 2014
Related CR Transmittal #: R1339OTN
Related Change Request (CR) #: CR 8620
Effective Date: October 1, 2013
Implementation Date: April 7, 2014

Provider Types Affected

This MLN Matters® article is intended as an update for non-hospice providers furnishing vaccines to hospice beneficiaries and submitting claims to Medicare Administrative Contractors (MACs).

Provider Action Needed

CMS issued CR 8620 to alert providers that any provider may furnish vaccines to hospice beneficiaries. Be sure your billing staffs are aware of this change.

Background

When CR 8098, Transmittal 1298, was published, effective October 1, 2013, it denied claims for vaccines furnished to hospice patients that were provided by anyone other than the patient's hospice provider. This was to enforce the statement in the *Medicare Claims Processing Manual*, chapter 18, section 10.2.4 that vaccines "may be covered when furnished by the hospice." CMS has determined that this enforcement is too restrictive, since the manual does not say "*only* when furnished by the hospice." CR 8620 removes the changes made to Medicare systems in CR 8098, in order to allow any provider to furnish vaccines to hospice beneficiaries.

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Key Points

- Your MAC will allow professional claims for vaccines (Influenza, PPV, and Hepatitis B) and vaccine administration containing modifier GW when the date of service falls within a hospice election.
- Your MAC will adjust vaccine claims with dates of service on or after October 1, 2013, which were previously rejected due to a hospice election, if you bring such claims to your MAC's attention.

Additional Information

The official instruction, CR 8620, issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1339OTN.pdf on the CMS website.

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at **1.866.590.6703** and choose Option 1.

Common Working File Information

SE1249 (Revised): HIPAA Eligibility Transaction System (HETS) to Replace Common Working File (CWF) Medicare Beneficiary Health Insurance Eligibility Queries

The Centers for Medicare & Medicaid Services (CMS) has issued a revision to the following ***Special Edition Medicare Learning Network® (MLN) Matters*** article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2012-MLN-Matters-Articles.html

MLN Matters® Number: SE1249 *Revised*
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Note: This article was revised on February 10, 2014, to update certain language to reflect the current **status of this change (see bolded language on page 2)**. Also, clarifications have been made to the last question in the Frequently Asked Questions section on page 3. All other information is unchanged.

Provider Types Affected

This MLN Matters® Special Edition Article is intended for health care providers, suppliers and their billing agents, software vendors and clearinghouses that use Medicare's Common Working File (CWF) queries to obtain their patient's Medicare health insurance eligibility information from Medicare contractors (carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), durable medical equipment Medicare administrative contractors (DME MACs), and/or Part A/B Medicare administrative contractors (A/B MACs)).

Provider Action Needed

If you currently use CWF queries to obtain Medicare health insurance eligibility information for Medicare fee-for service patients, you should immediately begin transitioning to the Medicare Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS).

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What You Need to Know

This article describes upcoming changes to Medicare beneficiary health insurance eligibility inquiry services that CMS will implement in the coming months. In April 2013, access to CWF eligibility query functions implemented in the Multi-Carrier System (MCS) and ViPS Medicare System (VMS), also referred to as PPTN and VPIQ, was terminated. CMS intends to terminate access to the other CWF eligibility queries implemented in the Fiscal Intermediary Standard System (FISS) Direct Data Entry (DDE), often referred to the HIQA, HIQH, ELGA and ELGH screens and HUQA. **Change Request 8248 creates the ability for CMS to terminate these queries. While termination was originally scheduled for April 2014, CMS is delaying the date. CMS will provide at least 90 days advanced notice of the new termination date.** This **will not** affect the use of DDE to submit claims or to correct claims and will not impact access to beneficiary eligibility information from Medicare Contractor's Interactive Voice Response (IVR) units and/or Internet portals.

Background

In 2005, CMS began offering HETS in a real-time environment to Medicare health care providers, suppliers and their billing agents, software vendors and clearinghouses. HETS is Medicare's Health Care Eligibility Benefit Inquiry and Response electronic transaction, ASCX12 270/271 Version 5010, adopted under HIPAA. HETS replaces the CWF queries, and is to be used for the business of Medicare; such as preparing an accurate Medicare claim or determining eligibility for specific services.

Key Points

General Information

CMS plans to discontinue access to the CWF queries through the shared systems. Medicare providers and their agents that currently access the CWF queries through the shared system screens will need to modify their business processes to use HETS to access Medicare beneficiary eligibility information.

HETS

HETS allows Medicare providers and their agents to submit and receive X12N 270/271 eligibility request and response files over a secure connection. Many Medicare providers and their agents are already receiving eligibility information from HETS. For more information about HETS and how to obtain access to the system, refer to the CMS HETS Help Web page at http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/HowtoGetConnectedHETS270271.html on the CMS website.

Frequently Asked Questions

Are Medicare providers that currently use CWF to obtain beneficiary eligibility information required to switch to HETS?

No, but it is recommended. Providers may also choose to use a Medicare Contractor's IVR or Internet portal.

What are the minimum data elements required in order to complete an eligibility search in HETS?

HETS applies search logic that uses a combination of four data elements: Health Insurance Claim Number (HICN), Medicare Beneficiary's Date of Birth, Medicare Beneficiary's Full Last Name (including Suffix, if applicable), and Medicare Beneficiary's Full First Name. The Date of Birth and First Name are optional, but at least one must be present.

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Does HETS return the same eligibility information that is currently provided by the CWF eligibility queries?

Changes are currently underway in HETS to return psychiatric information to authorized providers and to return Hospice period information in the same format as CWF. When these changes are made, HETS will return all of the information provided by the CWF eligibility queries that is needed to process Medicare claims. These changes will be in place before the termination date for the FISS DDE CWF query access.

HETS returns additional information that CWF does not return. For example, HETS returns:

- Part D plan number, address and enrollment dates; and
- Medicare Advantage Organization name, address, website and phone number.

The HETS 270/271 Companion Guide provides specific details about the eligibility information that is returned in the HETS 271 response. The guide is available at http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/Downloads/HETS270271CompanionGuide5010.pdf on the CMS website.

Additional Information

If you use a software vendor or clearinghouse to access Medicare beneficiary health insurance eligibility information, you should direct questions to your vendor or clearinghouse. If you have any questions about HETS, please contact the MCARE Help Desk at 1.866.324.7315.

Coverage Information

MM8418: Aprepitant for Chemotherapy Induced Emesis

The Centers for Medicare & Medicaid Services (CMS) has issued the following ***Medicare Learning Network® (MLN) Matters*** article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2014-MLN-Matters-Articles.html

MLN Matters® Number: MM8418
Related CR Release Date: February 21, 2014
Related CR Transmittal #: R180BP, R2883CP, and R163NCD
Related Change Request (CR) #: CR 8418
Effective Date: May 29, 2013
Implementation Date: July 7, 2014

Provider Types Affected

This MLN Matters® article is intended for providers and suppliers submitting claims to Part A Medicare administrative contractors (A MACs) and/or durable medical equipment MACs (DME MACs) for services to Medicare beneficiaries.

Provider Action Needed

This article is based on CR 8418, which informs MACs that, effective for claims with dates of service on or after May 29, 2013, CMS extends coverage of the oral antiemetic three-drug regimen of oral aprepitant, an oral 5HT3 antagonist, and oral dexamethasone to beneficiaries who are receiving certain anticancer chemotherapeutic agents. Make sure that your billing personnel are aware of these changes.

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Background

Chemotherapy induced emesis is the occurrence of nausea and vomiting during or after anticancer treatment with chemotherapy agents. The Social Security Act (the Act) permits oral drugs to be paid under Part B in very limited circumstances, one of which is antiemetic therapy administered immediately before and within 48 hours after anticancer chemotherapy as described in section1861(s)(2) of the Act. These drugs must fully replace the non-self-administered drug that would otherwise be covered.

On April 4, 2005, CMS announced a National Coverage Determination (NCD) for the use of the oral three-drug regimen of aprepitant, a 5HT3 antagonist, and dexamethasone for patients who are receiving certain highly emetogenic chemotherapeutic agents.

On May 29, 2013, CMS announced an update to that NCD, to cover the use of the oral antiemetic three-drug combination of oral aprepitant (J8501), an oral 5HT3 antagonist (Q0166, Q0179, Q0180), and oral dexamethasone (J8540) for patients receiving highly and moderately emetogenic chemotherapy. As a result, effective for services on or after May 29, 2013, the following anticancer chemotherapeutic agents have been added to the list of anticancer chemotherapeutic agents for which the use of the oral antiemetic 3-drug combination of oral aprepitant, an oral 5HT3 antagonist, and oral dexamethasone is deemed reasonable and necessary:

- Alemtuzumab (J9010);
- Azacitidine (J9025);
- Bendamustine (J9033);
- Carboplatin (J9045);
- Clofarabine (J9027);
- Cytarabine (J9098, J9100, J9110);
- Daunorubicin (J9150, J9151);
- Idarubicin (J9211);
- Ifosfamide (J9208);
- Irinotecan (J9206); and
- Oxaliplatin (J9263).

Please note the entire list includes the 11 new codes listed above and the 9 existing anticancer chemotherapeutic agents listed below:

- Carmustine (J9050);
- Cisplatin (J9060, J9062);
- Cyclophosphamide (J8530, J9070, J9080, J9090, J9091, J9092, J9093, J9094, J9095, J9096, J9097);
- Dacarbazine (J9130, J9140);
- Mechlorethamine (J9230);
- Streptozocin (J9320);
- Doxorubicin (J9000, J9001, J9002, Q2048, Q2049);
- Epirubicin (J9178); and
- Lomustine (S0178).

CMS also permits the MACs to determine coverage for other all-oral three-drug antiemesis regimens of aprepitant or any other Food and Drug Administration (FDA) approved oral NK-1 antagonist in combination with an oral 5HT3 antagonist and oral dexamethasone with the chemotherapeutic agents listed, or any other anticancer chemotherapeutic agents that are FDA-approved and may in the future be defined as highly or moderately emetogenic.

CMS is defining highly emetogenic chemotherapy and moderately emetogenic chemotherapy as those anticancer agents so designated in at least two of three guidelines published by the National Comprehensive Cancer Network (NCCN), American Society of Clinical Oncology (ASCO), and European Society of Medical Oncology (ESMO)/Multinational Association of Supportive Care in Cancer (MASCC). The inclusive examples are: NCCN plus ASCO, NCCN plus ESMO/MASCC, or ASCO plus ESMO/MASCC.

Until a specific code is assigned to the new drug, any new FDA-approved oral antiemesis drug (oral NK-1 antagonist or oral 5HT3 antagonist) as part of the three-drug regimen

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must be billed with the following not-otherwise-classified (NOC) code effective April 1, 2014, in the IOCE update:

- Q0181 - Unspecified oral dosage form, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for a IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen.

This NOC code must also be accompanied with a diagnosis code of an encounter for antineoplastic chemotherapy (ICD9/10 codes V58.11/Z51.11).

This coverage policy applies only to the oral forms of the three-drug regimen as a full replacement for their intravenous equivalents. All other indications or combinations for the use of oral aprepitant are non-covered under Medicare Part B, but may be considered under Medicare Part D.

For claims with dates of service on or after May 29, 2013, MACs will adjust claims processed before CR8418 was implemented if you bring those claims to the attention of your MAC.

Effective for claims with dates of service on or after May 29, 2013, MACS will deny lines for oral aprepitant (J8501), or NOC code Q0181 if an encounter for antineoplastic chemotherapy identified by ICD 9/10 codes V58.11/Z51.11 is not present. The denied lines will reflect the following messages on the remittance advice:

- Claim Adjustment Reason Code 96: Non-covered Charge(s)
- Remittance Advice Remarks Code (RARC) M100: We do not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours of administration of a covered chemotherapy; and
- RARC N386: This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have Web access, you may contact the contractor to request a copy of the NCD.

Additional Information

The official instruction, CR 8418, was issued to your MAC via three transmittals. The first updates the Medicare Benefit Policy Manual and that is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R180BP.pdf on the CMS website. The second updates the Medicare Claims Processing Manual and is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2883CP.pdf and the third updates the Medicare National Coverage Determinations Manual and it is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R163NCD.pdf on the CMS website.

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at **1.866.590.6703** and choose Option 1.

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Coverage Information

MM8468: Fluorodeoxyglucose (FDG) Positron Emission Tomography (PET) for Solid Tumors

The Centers for Medicare & Medicaid Services (CMS) has issued the following ***Medicare Learning Network® (MLN) Matters*** article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2014-MLN-Matters-Articles.html

MLN Matters® Number: MM8468
Related CR Release Date: February 6, 2014
Related CR Transmittal #: R2873CP/R162NCD
Related Change Request (CR) #: CR 8468
Effective Date: June 11, 2013
Implementation Date: March 7, 2014: Non-shared System Edits, July 7, 2014: Shared System Edits

Provider Types Affected

This MLN Matters® article is intended for physicians, providers and suppliers submitting claims to Medicare A/B administrative contractors (MACs) for services to Medicare beneficiaries.

What You Need to Know

This article is based on CR 8468, which advises you that, effective for claims with dates of service on and after June 11, 2013, CMS will cover three Flourodeoxyglucose Positron Emission Tomography (FDG PET) scans (without the Coverage with Evidence Development (CED) requirement) when used to guide subsequent management of anti-tumor treatment strategy after completion of initial anti-cancer therapy for the same cancer diagnosis. Coverage of any additional FDG PET scans (that is, beyond three) used to guide subsequent management of anti-tumor treatment strategy after completion of initial anti-cancer therapy for the same diagnosis will be determined by the local MACs. Make sure that your billing staffs are aware of these changes.

Background

CMS was asked to reconsider Section 220.6, of the National Coverage Determinations (NCD) Manual, to end the prospective data collection requirements across all oncologic indications of FDG PET in the context of this document. The term FDG PET includes PET/Computed Tomography (CT) and PET/Magnetic Resonance (MRI).

CMS is revising the NCD Manual, Section 220.6.17, to reflect that CMS has ended the CED requirement for 18 Fluorodeoxyglucose FDG PET and PET/CT and PET/MRI for all oncologic indications contained in Section 220.6.17 of the NCD Manual. This removes the current requirement for prospective data collection by the National Oncologic PET Registry (NOPR) for oncologic indications for FDG (HCPCS A9552) only.

Effective for services performed on or after June 11, 2013:

- The CED requirement has ended and modifier -Q0/-Q1, along with condition code 30 (institutional claims only), or V70.7 (both institutional and practitioner claims) are no longer required.
- MACs shall pay FDG PET claims for subsequent management, identified by CPT codes 78608, 78811, 78812, 78813, 78814, 78815, or 78816, modifier –PS, HCPCS A9552, and the same cancer dx code, which exceeded 3 FDG PET scans when the -KX modifier is included on the claim line.
- MACs will not search their files to identify claims processed prior to implementation of CR 8468; however, they will adjust such claims that you bring to their attention.

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MACs will deny subsequent treatment strategy (-PS) claims for FDG PET, which exceeded 3 FDG PET scans when a -KX modifier is not included on the claim line using the following:

- Claim Adjustment Reason Code (CARC) 96: "Non-covered charge(s). Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- Remittance Advice Remarks Code N435: "Exceeds number/frequency approved/allowed within time period without support documentation."
- Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file; or,
- Group Code PR assigning financial liability to the beneficiary if a claim is received with a GA modifier indicating a signed ABN is on file.

NOTE: For clarification purposes, as an example, each, different, cancer dx is allowed 1 initial treatment strategy (-PI modifier) PET scan and 3 subsequent treatment strategy (-PS modifier) PET scans without the -KX modifier. The 4th PET scan and beyond for the same cancer dx will always require the -KX modifier. If a different cancer dx is reported, that cancer dx will allow the same scenario as above, 1 initial, 3 subsequent, no -KX modifier required, 4 or more for same dx requires a -KX modifier.

Note: The only exception to the above frequency is with dx 185.0, prostate cancer, which is non-covered for initial treatment strategy. Therefore, all –PI modifiers for 185.0 would be denied, and –PS modifiers would follow the same frequency as all other cancer dx codes.

For claims with dates of service on or after July 7, 2014, contractors shall deny subsequent treatment strategy (-PS) claims for oncologic FDG PET scans when no initial treatment strategy (-PI) claim is present in history when appropriate. CWF will begin counting at this point. The prostate cancer exception above applies.

MACs shall deny subsequent treatment strategy (-PS) claims for oncologic FDG PET scan claims when no initial treatment strategy (-PI) claim is present in history using the following:

- CARC B5: "Coverage/program guidelines were not met or were exceeded."
- RARC N640: "Exceeds number/frequency approved/allowed within time period."
- Group Code PR assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.
- Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

Note: Providers should refer to Attachment A of CR8468 for appropriate oncologic diagnosis codes.

Please refer to MM6632, issued on October 16, 2009, available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6632.pdf on the CMS website, and MM7148, issued September 24, 2010, available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7148.pdf on the CMS website, for previous information on this coverage.

Additional Information

The official instruction, CR 8468, was issued to your MAC via two transmittals. The first transmittal updates the National Coverage Determinations Manual and it is available at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R162NCD.pdf on the CMS website. The second transmittal is at http://www.cms.hhs.gov/

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Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2873CP.pdf and that transmittal updates the Medicare Claims Processing Manual.

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at **1.866.590.6703** and choose Option 1.

Coverage Information

MM8525: National Coverage Determination (NCD) for Single Chamber and Dual Chamber Permanent Cardiac Pacemakers

The Centers for Medicare & Medicaid Services (CMS) has issued the following ***Medicare Learning Network® (MLN) Matters*** article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2014-MLN-Matters-Articles.html

MLN Matters® Number: MM8525
Related CR Release Date: February 7, 2014
Related CR Transmittal #: R161NCD and R2872CP
Related Change Request (CR) #: CR 8525
Effective Date: August 13, 2013
Implementation Date: July 7, 2014

Provider Types Affected

This MLN Matters® article is intended for physicians, other providers, and suppliers who submit claims to Medicare claims administration contractors (A/B Medicare administrative contractors (A/B MACs)) for cardiac pacemaker services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on CR 8525 which allows payment for nationally covered implanted permanent cardiac pacemakers, single chamber or dual chamber, for the indications outlined in the Medicare National Coverage Determinations Manual (Chapter 1, Part 1, Section 20.8, Cardiac Pacemakers) and the Medicare Claims Processing Manual (Chapter 32, Section 320, Billing Requirements for Cardiac Pacemakers: Single and Dual Chamber) which were revised by and included as attachments to CR 8525. CR 8525 is effective for claims with dates of service on or after August 13, 2013.

Make sure that your billing personnel know about these changes.

Background

Permanent cardiac pacemakers refer to a group of self-contained, battery operated, implanted devices that send electrical stimulation to the heart through one or more implanted leads. Single chamber pacemakers typically target either the right atrium or right ventricle. Dual chamber pacemakers stimulate both the right atrium and the right ventricle.

The implantation procedure is typically performed under local anesthesia and requires only a brief hospitalization. A catheter is inserted into the chest, and the pacemaker's leads are threaded through the catheter to the appropriate chamber(s) of the heart. The surgeon then makes a small "pocket" in the pad of the flesh under the skin on the upper portion of the chest wall to hold the power source. The pocket is then closed with stitches.

On August 13, 2013, CMS issued a National Coverage Determination (NCD). In this NCD, CMS concluded that implanted permanent cardiac pacemakers, single chamber

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or dual chamber, are reasonable and necessary for the treatment of non-reversible symptomatic bradycardia due to sinus node dysfunction and second and/or third degree atrioventricular block. Symptoms of bradycardia are symptoms that can be directly attributable to a heart rate less than 60 beats per minute (for example: syncope, seizures, congestive heart failure, dizziness, or confusion).

The following indications are covered for implanted permanent single chamber or dual chamber cardiac pacemakers:

1. Documented non-reversible symptomatic bradycardia due to sinus node dysfunction.
2. Documented non-reversible symptomatic bradycardia due to second degree and/or third degree atrioventricular block.

The following indications are non-covered for implanted permanent single chamber or dual chamber cardiac pacemakers:

1. Reversible causes of bradycardia such as electrolyte abnormalities, medications or drugs, and hypothermia.
2. Asymptomatic first degree atrioventricular block.
3. Asymptomatic sinus bradycardia.
4. Asymptomatic sino-atrial block or asymptomatic sinus arrest.
5. Ineffective atrial contractions (e.g., chronic atrial fibrillation or flutter, or giant left atrium) without symptomatic bradycardia.
6. Asymptomatic second degree atrioventricular block of Mobitz Type I unless the QRS complexes are prolonged or electrophysiological studies have demonstrated that the block is at or beyond the level of the His Bundle (a component of the electrical conduction system of the heart).
7. Syncope of undetermined cause.
8. Bradycardia during sleep.
9. Right bundle branch block with left axis deviation (and other forms of fascicular or bundle branch block) without syncope or other symptoms of intermittent atrioventricular block.
10. Asymptomatic bradycardia in post-myocardial infarction patients about to initiate long-term beta-blocker drug therapy.
11. Frequent or persistent supraventricular tachycardias, except where the pacemaker is specifically for the control of tachycardia.
12. A clinical condition in which pacing takes place only intermittently and briefly, and which is not associated with a reasonable likelihood that pacing needs will become prolonged.

MACs will determine coverage under the Social Security Act (Section 1862(a)(1)(A); see http://www.ssa.gov/OP_Home/ssact/title18/1862.htm) for any other indications for the implantation and use of single chamber or dual chamber cardiac pacemakers that are not specifically addressed in this NCD.

Note: MACs will accept the inclusion of the KX modifier on the claim line(s) as an attestation by the practitioner and/or provider of the service that documentation is on file verifying the patient has non-reversible symptomatic bradycardia (symptoms of bradycardia are symptoms that can be directly attributable to a heart rate less than 60 beats per minute (for example: syncope, seizures, congestive heart failure, dizziness, or confusion)).

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Other key notes for billing:

- MACs will pay **professional** claims for implanted permanent cardiac pacemakers, single chamber or dual chamber, provided the claim contains at least one of the CPT codes of 33206, 33207, or 33208 AND one of the following ICD-9-CM/ICD-10-CM diagnostic codes, and only when the claim is submitted with the KX modifier:
  - 426.0/I44.2
  - 426.12/I44.1
  - 426.13/I44.1
  - 427.81/I49.5, or
  - 746.86/Q24.6
- The following diagnosis codes can be covered at contractor discretion if submitted with at least one of the CPT codes and at least one of the diagnosis codes listed above along with the KX modifier:
  - 426.10 Atrioventricular block, unspecified/ I44.30 Unspecified atrioventricular block
  - 426.4 Right bundle branch block/ I45.10 Unspecified right bundle-branch block / I45.19 Other right bundle branch block
  - 427.0 Paroxysmal supraventricular tachycardia/ I47.1 Supraventricular tachycardia
- Contractors will return claim lines if the KX modifier is not present using the following message:
  - Claim Adjustment Reason Code (CARC) 4: The procedure code is inconsistent with the modifier used or a required modifier is missing.
  - Remittance Advice Remarks Code (RARC) N517: Resubmit a new claim with the requested information.
- Effective for claims with dates of service on or after August 13, 2013, MACs will pay **outpatient institutional** claims for implanted permanent cardiac pacemakers, single chamber or dual chamber, (codes C1785, C1786, C2619, or C2620) provided the claim contains the KX modifier, and contains at least one of the CPT codes 33206, 33207, or 33208, AND one of the following ICD-9_CM/ICD-10-CM diagnostic codes:
  - 426.0/I44.2
  - 426.12/I44.1
  - 426.13/I44.1
  - 427.81/I49.5, or
  - 746.86/Q24.6
- MACs will return outpatient institutional claims for implanted permanent cardiac pacemakers that do not meet the preceding requirements.
- The following diagnosis codes can be covered at contractor discretion if submitted with at least one of the CPT codes and diagnosis codes listed above:
  - 426.10 Atrioventricular block, unspecified/ I44.30 Unspecified atrioventricular block
  - 426.4 Right bundle branch block/ I45.10 Unspecified right bundle-branch block / I45.19 Other right bundle branch block
  - 427.0 Paroxysmal supraventricular tachycardia/ I47.1 Supraventricular tachycardia
- Effective for claims with dates of service on or after August 13, 2013, MACs will pay **inpatient** claims for implanted permanent cardiac pacemakers, single chamber or dual chamber, provided the claim contains one of the following ICD-9/ICD-10 diagnosis AND procedure codes:
  - 37.81/0JH604Z, 0JH634Z, 0JH804Z, 0JH834Z, 37.82/0JH605Z, 0JH635Z, 0JH805Z, 0JH835Z, or 37.83/0JH606Z, 0JH636Z, 0JH806Z, 0JH836Z, AND
  - 426.0/I44.2, 426.12/I44.1,
  - 426.13/I44.1, 427.81/I49.5, or 746.86/Q24.6
- The following diagnosis codes can be covered at contractor discretion if submitted with at least one of the CPT codes and diagnosis codes listed above:

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- 426.10 Atrioventricular block, unspecified/ I44.30 Unspecified atrioventricular block
- 426.4 Right bundle branch block/ I45.10 Unspecified right bundle-branch block / I45.19 Other right bundle branch block
- 427.0 Paroxysmal supraventricular tachycardia/ I47.1 Supraventricular tachycardia

In addition, be aware of the following:

- MACs will deny claims for implanted dual chamber for one of the following CPT codes: 33206, 33207, or 33208 and contains at least one of the following ICD-9-CM/ ICD-10-CM diagnosis codes (even if submitted with at least one of the acceptable diagnosis codes listed above):
  - 426.11/I44.0
  - 427.31/I48.1/I48.2/I48.91
  - 427.32/I48.2/I48.3/I48.4/ or I48.91
  - 427.89/I49.8/ R00.1
  - 780.2/R55

MACs will use the following messages when denying claims for implanted permanent cardiac pacemakers, single chamber or dual chamber, containing one of the following HCPCS and/or CPT codes: C1785, C1786, C2619, C2620, 33206, 33207, or 33208, and at least one diagnosis code from the list of ICD-9/ICD-10 diagnosis codes above:

- CARC 96: Non-covered charge(s).
- RARC N569: Not covered when performed for the reported diagnosis.
- Group Code - CO (contractual obligation), if claim received with GZ modifier indicating no signed Advance Beneficiary Notice (ABN) is on file or Group Code PR (Patient Responsibility) if occurrence code 32 indicating a signed ABN is on file or occurrence code 32 with modifier GA is present.

NCDs are binding on all MACs and contractors with the Federal government that review and/or adjudicate claims, determinations, and/or decisions, quality improvement organizations, qualified independent contractors, the Medicare appeals council, and administrative law judges (ALJs). An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD. (See the Social Security Act, Section 1869(f)(1)(A)(i), at http://www.ssa.gov/OP_Home/ssact/title18/1869.htm on the Internet.)

Additional Information

The official instruction, CR 8525, was issued to your MACs regarding this change via two transmittals. The first is the transmittal that updates the NCD Manual and it is available at may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R161NCD.pdf on the CMS website. The second transmittal updates the Medicare Claims Processing Manual and it is at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2872CP.pdf on the CMS website.

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at **1.866.590.6703** and choose Option 1.

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Coverage Information

MM8526: Medicare National Coverage Determination (NCD) for Beta Amyloid Positron Emission Tomography (PET) in Dementia and Neurodegenerative Disease

The Centers for Medicare & Medicaid Services (CMS) has issued the following ***Medicare Learning Network® (MLN) Matters*** article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2014-MLN-Matters-Articles.html

MLN Matters® Number: MM8526
Related CR Release Date: February 6, 2014
Related CR Transmittal #: 2871CP/160NCD
Related Change Request (CR) #: CR 8526
Effective Date: September 27, 2013
Implementation Date: July 7, 2014

Provider Types Affected

This MLN Matters® Article is intended for physicians and other providers who submit claims to Medicare A/B Medicare Administrative Contractors (A/B MACs) for services provided to Medicare beneficiaries with dementia or neurodegenerative disease.

What You Need to Know

Effective for claims with dates of service on or after, September 27, 2013, the Centers for Medicare & Medicaid Services (CMS) will only allow coverage for PET Aβ imaging (one PET Aβ scan per patient) through coverage with evidence development (CED) to: (1) develop better treatments or prevention strategies for Alzheimer's Disease (AD), or, as a strategy to identify subpopulations at risk for developing AD, or (2) resolve clinically difficult differential diagnoses (e.g., frontotemporal dementia (FTD) versus AD) where the use of PET Aβ imaging appears to improve health outcomes, when the patient is enrolled in an approved clinical study under CED.

Background

After careful consideration, effective for claims with dates of service on or after September 27, 2013,CMS believes that the evidence is insufficient to conclude that PET Aβ imaging improves health outcomes for Medicare beneficiaries with dementia or neurodegenerative disease. However, there is sufficient evidence that the use of PET Aβ imaging could be promising in certain scenarios. Therefore, Medicare will only allow coverage for PET Aβ imaging (one PET Aβ scan per patient) through CED to:

1. Develop better treatments or prevention strategies for AD, or, as a strategy to identify subpopulations at risk for developing AD, or
2. Resolve clinically difficult differential diagnoses (e.g., FTD versus AD) where the use of PET Aβ imaging appears to improve health outcomes, when the patient is enrolled in an approved clinical study under CED.

Health outcomes may include:

1. Avoidance of unnecessary or potentially harmful treatment or tests;
2. Improving, or slowing the decline of, quality of life (to include maintenance of independence) and cognitive and functional status; and,
3. Survival.

Outcomes may be short-term (e.g., related to meaningful changes in clinical management) or longterm (e.g., related to dementia outcomes).

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A list of ICD-9 and corresponding ICD-10 Codes for Beta Amyloid for Dementia and Neurodegenerative Diseases is in the following table.

ICD-9 Codes	Corresponding ICD-10 Codes
290.0 Senile dementia, uncomplicated	F03.90 Unspecified dementia without behavioral disturbance
290.10 Presenile dementia, uncomplicated	F03.90 Unspecified dementia without behavioral disturbance
290.11 Presenile dementia with delirium	F03.90 Unspecified dementia without behavioral disturbance
290.12 Presenile dementia with delusional features	F03.90 Unspecified dementia without behavioral disturbance
290.13 Presenile dementia with depressive features	F03.90 Unspecified dementia without behavioral disturbance
290.20 Senile dementia with delusional features	F03.90 Unspecified dementia without behavioral disturbance
290.21 Senile dementia with depressive features	F03.90 Unspecified dementia without behavioral disturbance
290.3 Senile dementia with delirium	F03.90 Unspecified dementia without behavioral disturbance
290.40 Vascular dementia, uncomplicated	F01.50 Vascular dementia without behavioral disturbance
290.41 Vascular dementia with delirium	F01.51 Vascular dementia with behavioral disturbance
290.42 Vascular dementia with delusions	F01.51 Vascular dementia with behavioral disturbance
290.43 Vascular dementia with depressed mood	F01.51 Vascular dementia with behavioral disturbance
294.10 Dementia in conditions classified elsewhere without behavioral disturbance	F02.80 Dementia in other diseases classified elsewhere without behavioral disturbance
294.11 Dementia in conditions classified elsewhere with behavioral disturbance	F02.81 Dementia in other diseases classified elsewhere with behavioral disturbance
294.20 Dementia, unspecified, without behavioral disturbance	F03.90 Unspecified dementia without behavioral disturbance
294.21 Dementia, unspecified, with behavioral disturbance	F03.91 Unspecified dementia with behavioral disturbance
331.11 Pick's Disease	G31.01 Pick's disease
331.19 Other Frontotemporal dementia	G31.09 Other frontotemporal dementia
331.6 Corticobasal degeneration	G31.85 Corticobasal degeneration
331.82 Dementia with Lewy Bodies	G31.83 Dementia with Lewy bodies
331.83 Mild cognitive impairment, so stated	G31.84 Mild cognitive impairment, so stated
780.93 Memory Loss	R41.1 Anterograde amnesia R41.2 Retrograde amnesia R41.3 Other amnesia (Amnesia NOS, Memory loss NOS)
V70.7 Examination for normal comparison or control in clinical research	Z00.6 Encounter for examination for normal comparison and control in clinical research program

Effective for claims with dates of service on or after September 27, 2013, MACs will return to provider/return as unprocessable claims for PET Aβ imaging, through CED during a clinical trial, not containing the following:

- Condition code 30, (for institutional claims only);
- Modifier Q0 and/or modifier Q1 as appropriate;
- ICD-9 dx code V70.7/ICD-10 dx code Z00.6 (on either the primary/secondary position);
- A PET HCPCS code 78811 or 78814;
- Dx codes (see list in table above); and
- Aβ HCPCS code A9586 or A9599.

MACs will return as unprocessable claims for PET Aβ imaging using the following messages:

- Claim Adjustment Reason Code (CARC) 4 – the procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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- Remittance Advice Remark Code (RARC) N517 – Resubmit a new claim with the requested information.
- RARC N519 – Invalid combination of HCPCS modifiers.

For claims with dates of service on or after September 27, 2013, Medicare will deny/reject claims for more than one PET Aβ scan; HCPCS code A9586 or A9599, in a patient's lifetime.

MACs will line-item deny claims for PET Aβ, HCPCS code A9586 or A9599, where a previous PET Aβ, HCPCS code A9586 or A9599 is paid in history using the following messages:

- CARC 149: "Lifetime benefit maximum has been reached for his service benefit category."
- RARC N587: "Policy benefits have been exhausted."
- Group Code: PR, assigning financial liability to the beneficiary if a claim is received with occurrence code 32 indicating a signed ABN is on file, or occurrence code 32 is present with modifier GA.
- Group Code: CO, assigning financial liability to the provider if a claim is received with a GZ modifier indicating no signed ABN is on file.

Note that MACs will not automatically adjust claims processed prior to implementation of CR8526, but they will adjust such claims that you bring to their attention.

Note: Each new beta amyloid radiopharmaceutical will require a separate code. Therefore, for the interim period, HCPCS code **(A9599)** - Radiopharmaceutical for beta-amyloid positron emission tomography (PET) imaging, diagnostic, per study dose shall be used with an effective date of January 1, 2014. After a new beta amyloid radiopharmaceutical is approved for a separate, individual HCPCS code, a subsequent CR will be issued to update this NCD policy.

Note: Contractors should refer to the business requirements in CR8526 well as general clinical trial billing requirements at Pub. 100-03, chapter 1, section 310, and Pub. 100-04, chapter 32, section 69. See Pub. 100-03, NCD Manual, chapter 1, section 220.6.20, for the coverage of Beta Amyloid PET in Neurodegenerative Disease and Dementia, and Pub. 100-04, Claims Processing Manual, chapter 13, section 60.12, for claims processing instructions.

Additional Information

The official instruction, CR 8526, is in two transmittals issued to your A/B MAC. The first transmittal updates the "National Coverage Determinations Manual" and it is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R160NCD.pdf on the CMS website. The second transmittal updates the *Medicare Claims Processing Manual* and it is at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2871CP.pdf on the CMS website.

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at **1.866.590.6703** and choose Option 1.

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Coverage Information

MM8597: Correction CR - Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131

The Centers for Medicare & Medicaid Services (CMS) has issued the following ***Medicare Learning Network® (MLN) Matters*** article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2014-MLN-Matters-Articles.html

MLN Matters® Number: MM8597
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Related CR Transmittal #: R2878CP
Related Change Request (CR) #: CR 8597
Effective Date: May 15, 2014
Implementation Date: May 15, 2014

Provider Types Affected

This MLN Matters® article is intended for physicians, providers, (including home health agencies), and suppliers that submit claims to Medicare administrative contractors (MACs), including home health & hospice Medicare administrative contractors (HH&H MACs), and durable medical equipment Medicare administrative contractors (DME MACs), for services to Medicare beneficiaries.

What You Need to Know

This article, based on CR 8597, provides the removal of language that was erroneously included in CR 8404 and in the Medicare Claims Processing Manual, Chapter 30, Sections 50.3 and 50.6.2. It also provides clarified manual instructions regarding home health agency issuance of the Advance Beneficiary Notice of Noncoverage (ABN) to dual eligible beneficiaries.

Background

The ABN is an Office of Management and Budget (OMB)-approved written notice issued by providers and suppliers for items and services provided under Medicare Part B, including hospital outpatient services, and care provided under Part A by home health agencies (HHAs), hospices, and religious non-medical healthcare institutes only.

Key Points of CR 8597

- With the exception of Durable Medical Equipment Prosthetic, Orthotics & Supplies (DMEPOS) suppliers, providers and suppliers who are not enrolled in Medicare cannot issue the ABN to beneficiaries. DMEPOS suppliers not enrolled as Medicare suppliers are required by statute to provide ABN notification prior to furnishing any items or services to Medicare beneficiaries.
- An example of an approved customization of the ABN which can be used by providers of laboratory services (Sample Lab ABN) is now available for download at http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html.
- When issuing ABNs to dual eligibles or beneficiaries having a secondary insurer, HHAs are permitted to direct the beneficiary to select a particular option box on the notice to facilitate coverage by another payer. This is an exception to the usual ABN issuance guidelines prohibiting the notifier from selecting one of the options for the beneficiary. When a Medicare claim denial is necessary to facilitate payment by Medicaid or a secondary insurer, HHAs should instruct beneficiaries to select Option 1 on the ABN. HHAs may add a statement in the “Additional Information” section to help a dual eligible better understand the payment situation such as, “We will submit a claim for this care with your other insurance,” or “Your Medical Assistance plan will pay for this care.” HHAs may also use the “Additional Information” on the ABN to

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include agency specific information on secondary insurance claims or a blank line for the beneficiary to insert secondary insurance information. Agencies can pre-print language in the "Additional Information" section of the notice.

- Some States have specific rules established regarding HHA completion of liability notices in situations where dual eligibles need to accept liability for Medicare noncovered care that will be covered by Medicaid. Medicaid has the authority to make this assertion under Title XIX of the Act, where Medicaid is recognized as the "payer of last resort," meaning other Federal programs like Medicare (Title XVIII) must pay in accordance with their own policies before Medicaid picks up any remaining charges. In the past, some States directed HHAs to select the third checkbox on the HHABN to indicate the choice to bill Medicare. On the ABN, the first check box under the "Options" section indicates the choice to bill Medicare and is similar to the third checkbox on the outgoing HHABN. Note: **If there has been a State directive to submit a Medicare claim for a denial, HHAs must mark the first check box when issuing the ABN.**
- HHAs serving dual eligibles should comply with existing HHABN State policy within their jurisdiction as applicable to the ABN unless the State instructs otherwise. The appropriate option selection for dual eligibles will vary depending on the State's Medicaid directive. If the HHA's State Medicaid office does NOT want a claim filed with Medicare prior to filing a claim with Medicaid, the HHA should direct the beneficiary to choose Option 2. When Option 2 is chosen based on State guidance, but the HHA is aware that the State sometimes asks for a Medicare claim submission at a later time, the HHA must add a statement in the "Additional Information" box such as "Medicaid will pay for these services. Sometimes, Medicaid asks us to file a claim with Medicare. We will file a claim with Medicare if requested by your Medicaid plan."

Additional Information

The official instruction, CR 8597, issued to your MAC regarding this change, may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2878CP.pdf on the CMS website.

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at **1.866.590.6703** and choose Option 1.

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Fee Schedule Information

MM8531 (Revised): Calendar Year (CY) 2014 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

The Centers for Medicare & Medicaid Services (CMS) has issued a revision to the following ***Medicare Learning Network® (MLN) Matters*** article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2013-MLN-Matters-Articles.html

MLN Matters® Number: MM8531 *Revised*
Related CR Release Date: December 13, 2013
Related CR Transmittal #: R2836CP
Related Change Request (CR) #: CR 8531
Effective Date: January 1, 2014
Implementation Date: January 6, 2014

Note: This article was revised on March 6, 2014, to provide updates regarding HCPCS codes changes that were effective January 1, 2014. The changes are on page 2 (bold). All other information remains unchanged.

Provider Types Affected

This MLN Matters® article is intended for providers and suppliers submitting claims to Medicare administrative contractors (MACs) for DMEPOS items or services paid under the DMEPOS fee schedule.

What You Need to Know

The CMS issued CR 8531 to advise providers of the Calendar Year (CY) 2014 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors, and other information related to the update of the DMEPOS fee schedule. Make sure your staffs are aware of these updates.

Background and Key Points of CR 8531

The DMEPOS fee schedules are updated on an annual basis in accordance with statute and regulations. The update process for the DMEPOS fee schedule is located in the Medicare Claims Processing Manual, Chapter 23, Section 60, which is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf on the CMS website. Payment on a fee schedule basis is required for Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by Section1834 (a), (h), and (i) of the Social Security Act (the Act). Also, payment on a fee schedule basis is a regulatory requirement at 42 CFR Section 414.102 for Parenteral and Enteral Nutrition (PEN) and splints, casts, and certain intraocular lenses.

Fee Schedule Files

The DMEPOS fee schedule file will also be available for providers and suppliers, as well as State Medicaid Agencies, managed care organizations, and other interested parties at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/ on the CMS website.

Healthcare Common Procedure Coding System (HCPCS) Codes Added/ Deleted

The following new codes are effective January 1, 2014:

- A7047 in the inexpensive/routinely purchased (IN) payment category;
- E0766 in the frequently serviced (FS) payment category; and E1352.

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The following new codes are in the prosthetics and orthotics (PO) payment category: L5969, L8679, L0455, L0457, L0467, L0469, L0641-L0643, L0648-L0651, L1812, L1833, L1848, L3678, L3809, L3916, L3918, L3924, L3930, L4361, L4387, and L4397.

The following code is deleted from the HCPCS effective January 1, 2014, and therefore, is removed from the DMEPOS fee schedule files: L0430

The following codes are deleted from the DMEPOS fee schedule files as of January 1, 2014: A4611, A4612, A4613, E0457, E0459, L8685, L8686, L8687, and L8688.

For gap-filling purposes, the 2013 deflation factors by payment category are listed in the following table:

Factor	Category
0.469	Oxygen
0.472	Capped Rental
0.473	Prosthetics and Orthotics
0.600	Surgical Dressings
0.653	Parental and Enteral Nutrition

Specific Coding and Pricing Issues

As part of this update, fee schedules for the following codes will be added to the DMEPOS fee schedule file effective January 1, 2014:

- A4387 Ostomy Pouch, Closed, With Barrier Attached, With Built-In Convexity, (I Piece), Each; and
- L3031 Foot, Insert/Plate, Removable, Addition to Lower Extremity Orthotic, High Strength, Lightweight Material, All Hybrid Lamination/Prepreg Composite, Each.

CMS is adjusting the fee schedule amounts for shoe modification codes A5503 through A5507 as part of this update in order to reflect more current allowed service data. Section 1833(o)(2)(C) of the Act required that the payment amounts for shoe modification codes A5503 through A5507 be established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes, A5512 or A5513. To establish the fee schedule amounts for the shoe modification codes, the base fees for codes A5512 and A5513 were weighted based on the approximated total allowed services for each code for items furnished during the second quarter of CY2004. For 2014, CMS is updating the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with more current allowed service data for each insert code. The base fees for A5512 and A5513 will be weighted based on the approximated total allowed services for each code for items furnished during the Calendar Year 2012. The fee schedule amounts for shoe modification codes A5503 through A5507 are being revised to reflect this change, effective January 1, 2014.

Off-the-Shelf Orthotics

Section 1847(a)(2)(C) of the Act mandates implementation of competitive bidding programs throughout the United States for awarding contracts for furnishing Off-The-Shelf (OTS) orthotics which require minimal self-adjustment for appropriate use and do not require expertise in trimming, bending, molding, assembling, or customizing to fit the individual. Regulations at 42 CFR 414.402 define the term “minimal self-adjustment” to mean an adjustment that the beneficiary, caretaker for the beneficiary, or supplier of the device can perform and that does not require the services of a certified orthotist, an individual who is certified by the American Board for Certification in Orthotics and Prosthetics, Inc, or by the Board for Orthotist/Prosthetist Certificationor an individual who has specialized training.

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As shown in the following table, 22 new codes are added to the HCPCS for OTS orthotics. In addition, as part of the review to determine which HCPCS codes for prefabricated orthotics describe OTS orthotics, it was determined that HCPCS codes for prefabricated orthotics describe items that are furnished OTS and items that require expertise in customizing the orthotic to fit the individual patient. Therefore, it was necessary to explode these codes into two sets of codes. One set is the existing codes revised, effective January 1, 2014, to only describe devices customized to fit a specific patient by an individual with expertise and a second set of new codes describing the OTS items.

Also, as shown in the table that follows for CY 2014, the fee schedule amounts for existing codes will be applied to the corresponding new codes added for the items furnished OTS. The cross walking of fee schedule amounts for a single code that is exploded into two codes for distinct complete items is in accordance with the instructions found in the Medicare Claims Processing Manual, Chapter 23,

Section 60.3.1, which is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf on the CMS website.

Prefabricated Orthotic Codes Split into Two Codes—Effective January 1, 2014			
Fee from Existing Code	**Crosswalk to New Off-The-Shelf and Revised Custom Fitted Orthotic Codes**	**Fee from Existing Code**	**Crosswalk to New Off-The-Shelf and Revised Custom Fitted Orthotic Codes**
L0454	L0455 and L0454	L1810	L1812 and L1810
L0456	L0457 and L0456	L1832	L1833 and L1832
L0466	L0467 and L0466	L1847	L1848 and L1847
L0468	L0469 and L0468	L3807	L3809 and L3807
L0626	L0641 and L0626	L3915	L3916 and L3915
L0627	L0642 and L0627	L3917	L3918 and L3917
L0630	L0643 and L0630	L3923	L3924 and L3923
L0631	L0648 and L0631	L3929	L3930 and L3929
L0633	L0649 and L0633	L4360	L4361 and L4360
L0637	L0650 and L0637	L4386	L4387 and L4386
L0639	L0651 and L0639	L4396	L4397 and L4396

Further information on the development of new OTS orthotic codes can be found at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/OTS_Orthotics.html on the CMS website.

Neurostimulator Devices

HCPCS codes, L8685, L8686, L8687, and L8688 are not included on the 2014 DMEPOS fee schedule file. They were removed from the file to reflect the change in the coverage indicators for these codes to invalid for Medicare ("I") effective January 1, 2014. However, code L8679 (Implantable Neurostimulator, Pulse Generator, Any Type) is added to the HCPCS and DMEPOS fee schedule file, effective January 1, 2014, for billing Medicare claims previously submitted under L8685, L8686, L8687 and L8688. The fee schedule amounts for code L8679 are based on the established Medicare fee schedule amounts for all types of pulse generators under the previous HCPCS code E0756 Implantable Neurostimulator Pulse Generator which was discontinued effective 12/31/2005. The payment amount is based on the explosion of code E0756 into four codes for different types of neurostimulator pulse generator systems which were not materially utilized in the Medicare program. As such, payment for code L8679 will revert back to the fee schedule amounts previously established for code E0756.

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Diabetic Testing Supplies

The fee schedule amounts for non-mail order diabetic testing supplies, without KL modifier, for codes A4233, A4234, A4235, A4236, A4253, A4256, A4258, A4259 are not updated by the covered item update for CY 2014. In accordance with Section 636(a) of the American Taxpayer Relief Act of 2012, the fee schedule amounts for these codes were adjusted in CY 2013 so that they are equal to the single payment amounts for mail order Diabetic Testing Supplies (DTS) established in implementing the national mail order Competitive Bidding Program (CBP) under Section 1847 of the Act. The non-mail order payment amounts on the fee schedule file will be updated each time the single payment amounts are updated which can happen no less often than every three years as CBP contracts are recompeted. The national CBP for mail order diabetic supplies is effective July 1, 2013, to June 30, 2016. The program instructions reviewing these changes are Transmittal 2709, Change Request (CR) 8325, dated May 17, 2013, and Transmittal 2661, Change Request (CR) 8204, dated February 22, 2013. You may review the MLN Matters® Articles for these CRs at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8325.pdf and http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8204.pdf on the CMS website.

Although for payment purposes the single payment amounts replace the fee schedule amounts for mail order DTS (KL modifier), the fee schedule amounts remain on the DMEPOS fee schedule file as reference data such as for establishing bid limits for future rounds of competitive bidding programs. The mail order DTS fee schedule amounts shall be updated annually by the covered item update, adjusted for Multi-Factor Productivity (MFP), which results in update of 1.0 percent for CY 2014. The single payment amount public use file for the national mail order competitive bidding program is available at http://www.dmecompetitivebid.com/palmetto/cbicrd2.nsf/DocsCat/Single%20Payment%20Amounts on the Internet.

CY2014 Fee Schedule Update Factor

For CY 2014, the update factor of 1.0 percent is applied to the applicable CY 2013 DMEPOS fee schedule amounts. In accordance with the statutory Sections 1834(a)(14) and 1886(b)(3)(B)(xi)(II) of the Act, the DMEPOS fee schedule amounts are to be updated for 2014 by the percentage increase in the consumer price index for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June of 2013, adjusted by the change in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business Multi-Factor Productivity (MFP).

The MFP adjustment is 0.8 percent and the CPI-U percentage increase is 1.8 percent. Thus, the 1.8 percentage increase in the CPI-U is reduced by the 0.8 percentage increase in the MFP resulting in a net increase of 1.0 percent for the update factor.

2014 Update to the Labor Payment Rates

The 2014 fees for HCPCS labor payment codes K0739, L4205, and L7520 are increased 1.8 percent effective for claims with dates of service from January 1, 2014, through December 31, 2014, and those rates are as follows:

STATE	K0739	L4205	L7520
AK	$27.40	$31.22	$36.73
AL	14.55	21.68	29.43
AR	14.55	21.68	29.43
AZ	17.99	21.66	36.21
CA	22.32	35.59	41.48

STATE	K0739	L4205	L7520
NC	14.55	21.68	29.43
ND	18.13	31.16	36.73
NE	14.55	21.66	41.04
NH	15.62	21.66	29.43
NJ	19.63	21.66	29.43

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STATE	K0739	L4205	L7520
CO	14.55	21.68	29.43
CT	24.30	22.16	29.43
DC	14.55	21.66	29.43
DE	26.79	21.66	29.43
FL	14.55	21.68	29.43
GA	14.55	21.68	29.43
HI	17.99	31.22	36.73
IA	14.55	21.66	35.23
ID	14.55	21.66	29.43
IL	14.55	21.66	29.43
IN	14.55	21.66	29.43
KS	14.55	21.66	36.73
KY	14.55	27.76	37.64
LA	14.55	21.68	29.43
MA	24.30	21.66	29.43
MD	14.55	21.66	29.43
ME	24.30	21.66	29.43
MI	14.55	21.66	29.43
MN	14.55	21.66	29.43
MO	14.55	21.66	29.43
MS	14.55	21.68	29.43
MT	14.55	21.66	36.73

STATE	K0739	L4205	L7520
NM	14.55	21.68	29.43
NV	23.18	21.66	40.12
NY	26.79	21.68	29.43
OH	14.55	21.66	29.43
OK	14.55	21.68	29.43
OR	14.55	21.66	42.32
PA	15.62	22.30	29.43
PR	14.55	21.68	29.43
RI	17.34	22.32	29.43
SC	$14.55	21.68	29.43
SD	16.26	21.66	39.35
TN	14.55	21.68	29.43
TX	14.55	21.68	29.43
UT	14.59	21.66	45.83
VA	14.55	21.66	29.43
VI	14.55	21.68	29.43
VT	15.62	21.66	29.43
WA	23.18	31.77	37.74
WI	14.55	21.66	29.43
WV	14.55	21.66	29.43
WY	20.28	28.89	41.04

2014 National Monthly Payment Amounts for Stationary Oxygen Equipment

CR8531 implements the 2014 national monthly payment amount for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390, and E1391), effective for claims with dates of service on or after January 1, 2014. As required by statute, the payment amount must be adjusted on an annual basis, as necessary, to ensure budget neutrality of the new payment class for Oxygen Generating Portable Equipment (OGPE). The updated 2014 monthly payment amount of $178.24 includes the 1 percent update factor for the 2014 DMEPOS fee schedule.

Please note that when updating the stationary oxygen equipment fees, corresponding updates are made to the fee schedule amounts for HCPCS codes E1405 and E1406 for oxygen and water vapor enriching systems. Since 1989, the fees for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

2014 Maintenance and Servicing Payment Amount for Certain Oxygen Equipment

CR 8531 also updates the 2014 payment amount for maintenance and servicing for certain oxygen equipment. You can read more about payment for claims for maintenance and servicing for oxygen equipment in MLN Matters® Articles, MM6792 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6792.pdf and MM6990 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6990.pdf on the CMS website.

To summarize, payment for maintenance and servicing of certain oxygen equipment can occur every 6 months beginning 6 months after the end of the 36th month of continuous use or end of the supplier's or manufacturer's warranty, whichever is later for either HCPCS code E1390, E1391, E0433 or K0738, billed with the "MS" modifier. Payment

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cannot occur more than once per beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary, for any 6-month period.

Per 42 CFR 414.210(5)(iii), the 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator. For CY 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in Section1834(a)(14) of the Act. Thus, the 2013 maintenance and servicing fee is adjusted by the 1 percent MFP-adjusted covered item update factor to yield a CY 2014 maintenance and servicing fee of $68.73 for oxygen concentrators and transfilling equipment.

Additional Information

The official instruction, CR 8531 issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2836CP.pdf on the CMS website.

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at **1.866.590.6703** and choose Option 1.

Financial Information

Address Change for Audit and Reimbursement Correspondence

Effective March 31, 2014, please send all correspondence for Audit & Reimbursement to the following address:

GS Audit and Reimbursement
PO Box 20020
Nashville, TN 37202

Physical Address for Documents:
CGS
Two Vantage Way
Nashville, TN 37228

Note: Send to the attention of Audit and Reimbursement.

Prior to this date, you may continue to use the existing address for Audit & Reimbursement, which is:

CGS Audit and Reimbursement
3021 Montvale Drive
Springfield, IL 62704

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Financial Information

MM8619: Implementation of Health Insurance Portability & Accountability Act (HIPAA) Standards and Operating Rules for Health Care Electronic Funds Transfers

The Centers for Medicare & Medicaid Services (CMS) has issued the following ***Medicare Learning Network® (MLN) Matters*** article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2014-MLN-Matters-Articles.html

MLN Matters® Number: MM8619
Related CR Release Date: February 21, 2014
Related CR Transmittal #: R1351OTN
Related Change Request (CR) #: CR 8619
Effective Date: July 1, 2014
Implementation Date: July 7, 2014

Provider Types Affected

This MLN Matters® article is intended for physicians, providers, and suppliers submitting claims to Medicare administrative contractors (MACs), including durable medical equipment Medicare administrative contractors (DME MACs) and home health and hospice (HH&H) MACs, for services to Medicare beneficiaries.

What You Need to Know

This article is based on CR 8619, which informs Medicare contractors that Section 1104 of the Affordable Care Act mandates the adoption of a standard for the Health Care Electronic Funds Transfers (EFT) HIPAA transaction and operating rules for the Health Care EFT and Remittance Advice Transaction.

The main intent of these standards and operating rules is to assure health plans transmit a trace number that allows providers to re-associate the EFT health care payment with its associate electronic remittance advice. Make sure that your billing staffs are aware of these changes.

Note that CR 8619 requires MACs to modify or change data elements currently inputted into payment information that is transmitted through the ACH (EFT) Network with electronic health care payments.

Physicians, other providers, and suppliers should be aware that, consequently, the payment information that a provider receives or that is transmitted from a provider's financial institution regarding the health care EFT payment may change as per these requirements. Specifically, the Company Entry Description and the TRN Segment that is reported or transmitted to a provider from its financial institution may change in terms of content or length.

Providers are urged to contact their financial institutions directly in order to understand the form in which payment information will be transmitted or reported on a per payment basis as a result of CR 8619. We suggest that providers should subsequently take steps to assure that the payment information that is changed as a result of related CR 8629 (see the related article at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8629.pdf can be accommodated by your accounting processes and systems.

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Background

The regulation adopting the Health Care EFT standards is available at https://www.federalregister.gov/articles/2012/01/10/2012-132/administrative-simplification-adoption-of-standards-for-health-care-electronic-funds-transfers-efts on the Internet.

The regulation adopting the EFT & ERA Operating Rules can be found at https://www.federalregister.gov/articles/2012/08/10/2012-19557/administrative-simplification-adoption-of-operating-rules-for-health-care-electronic-funds-transfers#h-4 on the Internet.

A new National Automated Clearinghouse Association (NACHA) standard for electronic healthcare claim payments went into effect on September 20, 2013, impacting all originators and receivers of electronic funds transfers (EFT) used to pay healthcare claims. This Healthcare EFT standard stems from the Affordable Care Act, which requires that healthcare payers must pay healthcare claim payments electronically using HIPAA standards if requested by the healthcare provider.

The standard designated for these claim payments is the Healthcare EFT Standard, which is a NACHA CCD+ transaction that includes the ASC X12 835 TRN data segment in the addenda record. The Healthcare EFT Standard requires the following:

- Company Entry Description of "HCCLAIMPMT" to identify the payment as healthcare;
- Company Name should be the health plan or third party administrator paying the claim;
- An addenda record must be included with a Record Type Code of "7" and an Addenda Type Code equal to "05"; and
- Payment Related Information in the addenda record must contain the ASC X12 835 TRN (Re-association Trace Number) data segment that is included on the electronic remittance advice.

Healthcare providers will use the data within the addenda record to match the payment to the electronic remittance advice, which is sent to the provider separate from the payment. As a result, specific addenda formatting requirements must be followed for healthcare EFT payments. The TRN data segment must contain the following data elements, separated by an asterisk "*."

Example: TRN*1*12345*1512345678*9999999~

TRN, TRN01, TRN02, TRN03, TRN04, Segment Terminator

* data element separator

Element	Element Name	Mandatory or Optional	Data Content
TRN	Re-association Trace Number	M	ASC X12 835 segment identifier. This is always "TRN."
TRN01	Trace Type Code	M	Trace Type Code is always a "1."
TRN02	Re-association Information	M	This data element must contain the EFT trace number.
TRN03	Origination Company ID	M	A unique identifier designating the company initiating the funds transfer. This must be a "1" followed by the payer's Tax Identification Number (TIN).
TRN04	Reference Identification	O	This data element is required when information beyond the Originating Company Identifier in TRN03 is necessary for the payee to identify the source of the payment.
Segment Terminator	Segment Terminator	M	The TRN data segment in the addenda record must end with either a tilde "~" or a backslash "\."

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Additional Information

The official instruction, CR 8619, issued to your MAC regarding this change, is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1351OTN.pdf on the CMS website.

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at **1.866.590.6703** and choose Option 1.

Financial Information

MM8629: Implementation of National Automated Clearinghouse Association (NACHA) Operating Rules for Health Care Electronic Funds Transfers (EFT)

The Centers for Medicare & Medicaid Services (CMS) has issued the following ***Medicare Learning Network® (MLN) Matters*** article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2014-MLN-Matters-Articles.html

MLN Matters® Number: MM8629
Related CR Release Date: February 21, 2014
Related CR Transmittal #: R1349OTN
Related Change Request (CR) #: CR 8629
Effective Date: July 1, 2014
Implementation Date: July 7, 2014

Provider Types Affected

This MLN Matters® article is intended for physicians, other providers, and suppliers submitting claims to Medicare administrative contractors (MACs), including home health & hospice MACs (HH&H MACs) and durable medical equipment Medicare administrative contractors (DME MACs) for services to Medicare beneficiaries.

What You Need to Know

This article is based on CR 8629 which informs MACs that they must comply with NACHA Operating Rules that are applicable to initiators of health care payments. CR 8629 requires MACs to modify or change data elements currently inputted into payment information that is transmitted through the ACH (EFT) Network with electronic health care payments. The overarching goal of the requirements of CR 8629 are to assure that providers receiving health care payments via EFT will receive a “trace number” that facilitates automatic reassociation of the EFT health care payment with its associated remittance advice.

Physicians, other providers, and suppliers should be aware that, consequently, the payment information that a provider receives or that is transmitted from a provider’s financial institution regarding the health care EFT payment may change as per these requirements. Specifically, the Company Entry Description and the TRN Segment that is reported or transmitted to a provider from its financial institution may change in terms of content or length.

Providers are urged to contact their financial institutions directly in order to understand the form in which payment information will be transmitted or reported on a per payment basis as a result of CR 8629. We suggest that providers should subsequently take steps to assure that the payment information that is changed as a result of CR 8629 can be accommodated by your accounting processes and systems.

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Background

In support of Health Insurance Portability & Accountability Act of 1996 (HIPAA) Operating Rules for health care EFT and remittance advice transactions adopted by HHS, NACHA – The Electronic Payments Association has adopted its own operating rules that apply to ACH transactions that are health care payments from health plans to providers. NACHA manages the development, administration and governance of the ACH Network used by all types of financial networks and represents more than 10,000 financial institutions.

A new NACHA standard for electronic healthcare claim payments went into effect on September 20, 2013, impacting all originators and receivers of EFT used to pay healthcare claims. This Healthcare EFT standard stems from the Affordable Care Act, which requires that healthcare payers must pay healthcare claim payments electronically using HIPAA standards if requested by the healthcare provider.

The standard designated for these claim payments is the Healthcare EFT Standard, which is a NACHA CCD+ transaction that includes the ASC X12 835 TRN data segment in the addenda record. The Healthcare EFT Standard requires the following:

- Company Entry Description of "HCCLAIMPMT" to identify the payment as healthcare;
- Company Name should be the health plan or third party administrator paying the claim;
- An addenda record must be included with a Record Type Code of "7" and an Addenda Type Code equal to "05"; and
- Payment Related Information in the addenda record must contain the ASC X12 835 TRN (Re-association Trace Number) data segment that is included on the electronic remittance advice.

Healthcare providers will utilize the data within the addenda record to match the payment to the electronic remittance advice, which is sent to the provider separate from the payment. As a result, specific addenda formatting requirements must be followed for healthcare EFT payments. See "Healthcare EFT Standard Format" in the Medicare IOM for more information.

Example:

TRN*1*12345*1512345678*9999999~

TRN, TRN01, TRN02, TRN03, TRN04, Segment Terminator

*** data element separator**

The following table explains this example:

Element	Element Name	Mandatory or Optional	Data Content
TRN	Reassociation Trace Number	M	ASC X12 835 segment identifier. This is always "TRN."
TRN01	Trace Type Code	M	Trace Type Code is always a "1."
TRN02	Reassociation Information	M	This data element must contain the EFT trace number.
TRN03	Origination Company ID	M	A unique identifier designating the company initiating the funds transfer. This must be a "1" followed by the payer's Tax Identification Number (TIN).
TRN04	Reference Identification	O	This data element is required when information beyond the Originating Company Identifier in TRN03 is necessary for the payee to identify the source of the payment.
Segment Terminator	Segment Terminator	M	The TRN data segment in the addenda record must end with either a tilde "~" or a backslash "\."

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Additional Information

For information on the NACHA Operating Rules that apply to health care payments, particularly with regard to requirements for originators, see https://healthcare.nacha.org/healthcarerules. The official instruction, CR 8629 issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1349OTN.pdf on the CMS website.

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at **1.866.590.6703** and choose Option 2.

Hospital Information

MM8273 (Rescinded): Common Working File (CWF) and Fiscal Intermediary Standard System (FISS) Informational Unsolicited Response (IUR) or Denial of Inpatient Services Related to a Hospice Terminal Diagnosis

The Centers for Medicare & Medicaid Services (CMS) has rescinded the following ***Medicare Learning Network® (MLN) Matters*** article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2014-MLN-Matters-Articles.html

MLN Matters® Number: MM8273 *Rescinded*
Related CR Release Date: November 7, 2013
Related CR Transmittal #: R1312OTN
Related Change Request (CR) #: CR 8273
Effective Date: April 1, 2014
Implementation Date: April 7, 2014

Note: This article was rescinded on February 20, 2014, as the related CR8273 was rescinded.

Hospital Information

MM8445: Implementing the Part B Inpatient Payment Policies from CMS-1599-F

The Centers for Medicare & Medicaid Services (CMS) has issued the following ***Medicare Learning Network® (MLN) Matters*** article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2014-MLN-Matters-Articles.html

MLN Matters® Number: MM8445
Related CR Release Date: February 7, 2014
Related CR Transmittal #: R2877CP
Related Change Request (CR) #: CR 8445
Effective Date: For Admissions occurring on or after October 1, 2013
Implementation Date: April 7, 2014

Provider Types Affected

This MLN Matters® article is intended for providers and suppliers who submit claims to Medicare claims administration contractors (MACs) for services provided to Medicare beneficiaries.

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Provider Action Needed

This article is based on CR 8445 which provides details regarding the implementation of payment policies related to hospital Part B inpatient billing from the final regulation CMS-1599-F. Make sure that your billing staffs are aware of these changes.

Background

CMS issued the Fiscal Year (FY) 2014 Inpatient Prospective Payment System (IPPS) / Long-Term Care Hospital (LTCH) Final Rule (CMS-1599-F; CMS-1455-F) on August 19, 2013, in which CMS finalized a policy to provide additional payment under Medicare Part B for hospital inpatient services when a hospital inpatient admission is determined not reasonable and necessary for payment under Medicare Part A, and the beneficiary should have been treated as a hospital outpatient. You can find the CMS "FY 2014 IPPS/LTCH Final Rule Home Page" at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2014-IPPS-Final-Rule-Home-Page.html on the CMS website.

CR 8445 provides claims processing guidance related to the implementation of this policy for all hospitals and critical access hospitals (CAHs). CR 8445 contains related revisions to the Medicare Claims Processing Manual (Pub. 100-04), and CMS will issue companion revisions to the Medicare Benefit Policy Manual (Pub. 100-02) in a separate release.

Payment of Part B Inpatient Services

When Medicare Part A payment cannot be made because an inpatient admission is found to be not reasonable and necessary and the beneficiary should have been treated as a hospital outpatient rather than a hospital inpatient, Medicare will allow payment under Part B of all hospital services that were furnished and would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted to the hospital as an inpatient, except for those services that specifically require an outpatient status, provided the beneficiary is enrolled in Medicare Part B and provided the allowed timeframe for submitting claims is not expired. The policy applies to all hospitals and critical access hospitals (CAHs) participating in Medicare, including those paid under a prospective payment system or alternative payment methodology such as State cost control systems, and to emergency hospitals services furnished by nonparticipating hospitals. In this document and in CR 8445, the term "hospital" includes all hospitals and CAHs, regardless of payment methodology, unless otherwise specified.

This policy applies when a hospital determines under Medicare's utilization review requirements that a beneficiary should have received hospital outpatient rather than hospital inpatient services, and the beneficiary has already been discharged from the hospital (commonly referred to as hospital self-audit). If the hospital already submitted a claim to Medicare for payment under Part A, the hospital must cancel its Part A claim prior to submitting a claim for payment of Part B services. Whether or not the hospital has submitted a claim to Part A for payment, Medicare requires the hospital to submit a "no pay" Part A claim indicating that the provider is liable under section 1879 of the Social Security Act for the cost of the Part A services. The hospital may then submit an inpatient claim for payment under Part B for all services that would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient rather than admitted as a hospital inpatient, except where those services specifically require an outpatient status.

Those services that specifically require an outpatient status includes those that are, by definition, provided to hospital outpatients and not inpatients, including:

- Hospital outpatient visits (emergency department and clinic visits);
- Observation services;

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- Diabetes Self-Management Training Services.

Hospitals may not bill for inpatient routine services in a hospital. Inpatient routine services generally are those services included by the provider in a daily service charge – sometimes referred to as the "room and board" charge.

Payable and non-payable services are further described in the update of the Medicare Claims Processing Manual (Chapter 4 (Part B Hospital – Including Inpatient Hospital Part B and OPPS); Section 240 which is attached to CR 8445.

Part B inpatient services are billed using the 12X TOB.

For Part B inpatient services furnished by the hospital that are not paid under the OPPS, but rather under some other Part B payment mechanism, Part B inpatient payment will be made pursuant to the Part B fee schedules or prospectively determined rates for which payment is made for these services when provided to hospital outpatients. All hospitals billing Part A services are eligible to bill the Part B inpatient services, including:

- Short-term acute-care hospitals paid under the IPPS;
- Hospitals paid under the OPPS
- Long-Term Care Hospitals (LTCHs);
- Inpatient Psychiatric Facilities (IPFs) and IPF hospital units;
- Inpatient Rehabilitation Facilities (IRFs) and IRF hospital units;
- Critical Access Hospitals (CAHs);
- Children's hospitals;
- Cancer hospitals; and
- Maryland waiver hospitals.

Hospitals paid under the OPPS continue billing the OPPS for Part B inpatient services. Hospitals that are excluded from payment under the OPPS in Title 42 of the Code of Federal Regulations (CFR) Section 419.20(b) are eligible to bill Part B inpatient services under their non-OPPS Part B payment methodologies. For more information regarding 42 CFR 419.20(b), refer to http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&SID=f0a3c4c0d051e60e0bf1fe559cc9dfdf&tpl=/ecfrbrowse/Title42/42cfr419_main_02.tpl on the Internet.

Other Circumstances When Part A Payment Cannot Be Made

CMS notes that there are no changes to the policies for billing Part B under other circumstances when Part A payment cannot be made. For example, when beneficiaries treated as hospital inpatients are either not entitled to Part A at all, or are entitled to Part A but have exhausted their Part A benefits, hospitals may only bill for a limited set of ancillary Part B inpatient services. Some of these services are typically packaged for payment under the OPPS, and the primary service into which they are packaged is not payable. In these circumstances, CMS will provide separate payment for the ancillary Part B inpatient service. For example, hospitals should continue to use HCPCS code C9899 created by CMS to obtain separate payment under this provision for certain implantable prosthetic devices which replace all or part of an internal body organ and do not have pass-through payment status. However CMS revised the Medicare Claims Processing Manual Ch. 4 Sec. 240 to specify that this code should not be used when billing Part B following a reasonable and necessary Part A denial, because the primary service (the implantation surgery) is a payable Part B inpatient service and payment of the device is packaged with the surgery.

Payment of Part B Services in the Payment Window for Outpatient Services Treated as Inpatient Services When Payment Cannot Be Made Under Part A

Medicare continues the current policy allowing hospitals to bill Part B for services furnished by the hospital that were bundled into the original Part A claim under the 3-day (1-day for non-IPPS hospitals) payment window prior to the inpatient admission. CMS revised the manual to clarify that if these services were furnished by the hospital (including referred hospital lab tests), they may be billed to Part B. CMS is clarifying that

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both 13X (85x for CAH) and 14X TOB may be submitted for payment of these services, subject to the revised manual instructions.

Timely Filing and Supporting Documentation

Timely filing restrictions will apply for the Part B services billed. Therefore, Part B claims that are filed beyond 12 months from the date of service will be rejected as untimely and will not be paid. Hospitals are required to maintain documentation to support the services billed on the Part B claim(s).

Provider and Beneficiary Liability

A "no-pay" provider-liable Part A claim (110 TOB) must be present in the claims history before accepting the Part B claim(s) for payment. The no-pay Part A claim indicates that the provider and not the beneficiary is liable under the Social Security Act (Section 1879; see http://www.socialsecurity.gov/OP_Home/ssact/title18/1879.htm) for the cost of the Part A services. Submission of this claim cancels any claim that may have already been submitted by the hospital for payment under Part A. When a Medicare review contractor denies a Part A claim for medical necessity, the claims system converts the originally submitted 11X claim to a 110 TOB on behalf of the hospital. When the hospital and not the beneficiary is liable for the cost of the Part A services (pursuant to the limitation on liability provision in Section 1879 of the Social Security Act), the beneficiary is not responsible for paying the deductible and coinsurance charges related to the denied Part A claim and the beneficiary's Medicare utilization record is not charged for the services and items furnished. The hospital must refund any payments (including coinsurance and deductible) made by the beneficiary or third party for a denied Part A claim when the provider is held financially liable for that denial (see section 1879(b) of the Act; 42 CFR § 411.402; and chapter 30 §§ 30.1.2, "Beneficiary Determined to Be Without Liability" and 30.2.2, "Provider/Practitioner/Supplier is Determined to Be Liable" of the Medicare Claims Processing Manual).

If the beneficiary's liability under Part A for the initial claim submitted for inpatient services is greater than the beneficiary's liability under Part B for the inpatient services they received, the hospital must refund the beneficiary the difference between the applicable Part A and Part B amounts. Conversely, if the beneficiary's liability under Part A is less than the beneficiary's liability under Part B for the services they received, the beneficiary may face greater cost sharing.

Summary of Business Requirements for CR 8445:

- MACs will ensure that provider submitted medical necessity denial claims contain the Occurrence Span Code "M1" and dates on the inpatient claim.
  - Hospital part B Inpatient service claims that are billed after a Medical Necessity denial should contain the following data elements:
    - A treatment authorization code of A/B Rebilling submitted by a provider.
      - **NOTE: Providers submitting an 837I** will be instructed to place the appropriate Prior Authorization code above into Loop 2300 REF02 (REF01 = G1) as follows: REF*G1*A/B Rebilling~
        - > **For DDE or paper Claims,** "A/B Rebilling" will be added in FL 63.
    - A condition code "W2" attesting that this is a rebilling and no appeal is in process, and
      - The original denied inpatient claim (CCN/DCN/ICN) number, and
        - > **NOTE: Providers submitting an 837I** will be instructed to place the DCN in the Billing Notes loop 2300/NTE in the format: NTE*ADD*ABREBILL12345678901234~

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> **For DDE or paper Claims,** Providers will be instructed to use the word "ABREBILL" plus the denied inpatient DCN/CCN/ICN will be added to the Remarks field (form locator #80) on the claim using the following format: "ABREBILL12345678901234".

  - NOTE: The numeric string above (12345678901234) is meant to represent original claim DCN/ICN numbers from the inpatient denial.

- MACs will Return to Provider a TOB 121 A/B Rebilling claim that does not have a medical denied 11x claim in history that matches the DCN in remarks.
- MACs will dismiss redetermination requests of Part A 11x claims if the provider has previously billed a 121 A/B rebilling claim. However, contractors will accept appeal requests of A/B rebilled 121 claims.
- Medicare will not allow observation services (Revenue Code 762), and outpatient visits (Revenue Codes 45x and 51x) to be billed on the A/B rebilling 121 TOB claim. (This includes G0738, G0739, 99201-99215, 99281-99285, G0380-G0384, and G0463.)
- Additionally, Medicare's claims processing systems will set edits to prevent payment on Type of Bill 12x for claims containing the revenue codes listed as follows:

010x	011x	012x	013x	014x	015x	016x	017x
018x	019x	020x	021x	022x	023x	024x	029x
0390		0399	045x	050x	051x	052x	054x
055x	056x	057x	058x	059x	060x	0630	0631
0632	0633	0637	064x	065x	066x	067x	068x
072x	0762		082x	083x	084x	085x	088x
089x	0905	0906	0907	0912	0913	093x	0941
0943	0944	0945	0946	0947	0948	095x	0960
0961	0962	0963	0964*	0969			
097x	098x	099x	100x	210x	310x		

* In the case of Revenue Code 0964, this is used by hospitals that have a CRNA exception.

Additional Information

The official instruction, CR 8445 issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2877CP.pdf on the CMS website.

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at **1.866.590.6703** and choose Option 1.

You can review the FY 2014 IPPS/LTCH Final Rule (CMS-1599-F; CMS-1455-F) displayed in the Federal Register Vol. 78, No. 160 dated August 19, 2013, at http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf on the CMS website.

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Hospital Information

MM8546: Addition of New Fields and Expansion of Existing Model 1 Discount Percentage Field in the Inpatient Hospital Provider Specific File (PSF) and Renaming Payment Fields in the Inpatient Prospective Payment System (IPPS) Pricer Output

The Centers for Medicare & Medicaid Services (CMS) has issued the following ***Medicare Learning Network® (MLN) Matters*** article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2014-MLN-Matters-Articles.html

MLN Matters® Number: MM8546
Related CR Release Date: February 5, 2014
Related CR Transmittal #: R2870CP
Related Change Request (CR) #: CR 8546
Effective Date: July 1, 2014
Implementation Date: July 7, 2014

Provider Types Affected

This MLN Matters® article is intended for providers and suppliers submitting institutional claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries.

Provider Action Needed

This article is based on CR 8546 which informs MACs about changes to the PSF. The PSF is maintained by MACs to facilitate proper payments to providers.

Note: CR8546 is not implementing the Hospital Acquired Condition (HAC) Reduction Program initiative or the Electronic Health Records (EHR) Incentive Program, but is only preparing the Centers for Medicare & Medicaid Services (CMS) systems for the future. Specific instructions implementing these programs, including manual updates to Addendum A of the "Medicare Claims Processing Manual," will be issued in the future in the event these policies are finalized.

Make sure that your billing staffs are aware of these changes.

Background

Section 3008 of the Affordable Care Act establishes a program, beginning in FY 2015, for IPPS hospitals to improve patient safety, by imposing financial penalties on hospitals that perform poorly with regard to certain HACs. HACs are conditions that patients did not have when they were admitted to the hospital, but which developed during the hospital stay. Under the HAC Reduction Program, hospitals that rank in the lowest-performing quartile of selected HAC measures will be subject to a reduction of what they would otherwise be paid under the IPPS.

Section 3133 of the Affordable Care Act provides for an additional payment for a hospital's uncompensated care. Each Medicare Disproportionate-Share (DSH) hospital will receive an Uncompensated Care Payment (UCP) based on its share of uncompensated care as calculated by CMS for Medicare DSH hospitals. Currently, for FY 2014, the estimated per claim UCP amount is stored in PRICER. In order to make changes to the amounts more efficient, CMS is adding the estimated per claim UCP amount to the PSF.

The Medicare EHR Incentive Program provides incentive payments for eligible acute-care inpatient hospitals that are meaningful users of certified EHR technology. Eligible-acute care inpatient hospitals are defined as "subsection (d) hospitals"—which are generally hospitals that are paid under the IPPS and are located in one of the 50 states

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or the District of Columbia. Hospitals that are not meaningful users of certified EHR technology will be subject to payment adjustments beginning in FY 2015.

Model 1 of the Bundled Payments for Care Improvement (BPCI) initiative provides a discounted payment to Model 1 participating hospitals for the acute-care hospital stay. The discount will be phased in over the performance period of 3 years. To accommodate the 0.5% discount for months 7 to 12, the Model 1 discount percentage field in the PSF must be expanded.

SUMMARY OF CR8546 CHANGES

The inpatient PSF will be expanded to include 3 new fields and an expansion of the existing Model 1 discount percentage field as follows:

1. Add an indicator for hospitals subject to the Hospital Acquired Conditions (HAC) reduction program for future implementation.
2. Add an estimated interim per claim Uncompensated Care Payment amount.
3. Add an indicator for hospitals subject to an Electronic Health Records Incentive Program reduction for future implementation.
4. Expand the existing 2-byte Model 1 discount percentage field to 3-bytes.

In order to avoid confusion with the 4 new payment amount fields created in CR 8217, we are renaming them here. In addition, we are redefining existing filler in the output record PRICER returns to Fiscal Intermediary Standard System (FISS) to accommodate future policy and/or legislative changes that might require system changes.

The new fields are:

- PPS- EHR-PAYMENT-ADJUST-AMT PIC S9(07)V9(02).
- PPS-FLX5- PAYMENT PIC S9(07)V9(02).
- PPS-FLX6- PAYMENT PIC S9(07)V9(02)
- PPS-FLX7- PAYMENT PIC S9(07)V9(02).

The renamed fields are:

- From PPS-FLX1-PAYMENT to PPS-UNCOMP-CARE-AMOUNT
- From PPS-FLX2-PAYMENT to PPS-BUNDLE-ADJUST-AMT
- From PPS-FLX3-PAYMENT to PPS-VAL-BASED-PURCH-ADJUST-AMT
- From PPS-FLX4-PAYMENT to PPS-READMIS-ADJUST-AMT

Additional Information

The official instruction, CR 8546 issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2870CP.pdf on the CMS website.

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at **1.866.590.6703** and choose Option 1.

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Hospital Information

MM8653: April 2014 Update of the Hospital Outpatient Prospective Payment System (OPPS)

The Centers for Medicare & Medicaid Services (CMS) has issued the following ***Medicare Learning Network® (MLN) Matters*** article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2014-MLN-Matters-Articles.html

MLN Matters® Number: MM8653
Related CR Release Date: February 28, 2014
Related CR Transmittal #: R2894CP
Related Change Request (CR) #: CR 8653
Effective Date: April 1, 2014
Implementation Date: April 7, 2014

Provider Types Affected

This MLN Matters® article is intended for providers and suppliers who submit claims to Part A Medicare administrative contractors (A MACs) and home health and hospice (HH&H) MACs for services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on CR 8653 which describes changes to and billing instructions for various payment policies implemented in the April 2014 OPPS update. The April 2014 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in CR 8653. Be sure your billing staff are aware of these changes.

Background

CR 8653 describes changes to and billing instructions for various payment policies implemented in the April 2014 OPPS update. The April 2014 I/OCE and OPPS Pricer will reflect the HCPCS, APC, HCPCS Modifier, Status Indicators (SIs), and Revenue Code additions, changes, and deletions identified CR 8653.

The April 2014 revisions to I/OCE data files, instructions, and specifications are provided in the April 2014 I/OCE CR 8658. Upon release of CR 8658, a related MLN Matters® article can be found at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8658.pdf on the CMS website.

The key changes in the April 2014 update to the hospital OPPS are summarized in the following sections.

Changes to Device Edits for April 2014

The most current list of device edits can be found under "Device and Procedure Edits" at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/ on the CMS website. Failure to pass these edits will result in claims being returned to the provider.

No Cost/ Full Credit and Partial Credit Devices

Effective January 1, 2014, CMS will no longer recognize the modifier FB (Item provided without cost to provider, supplier, or practitioner, or credit received for replaced device) or the modifier FC (Partial credit received for replaced device), which are used to identify a device that is furnished without cost or with a full or partial credit. Also effective January 1, 2014, for claims with APCs that require implantable devices and have significant device offsets (greater than 40 percent), the amount of the device credit will be specified in the amount portion for value code "FD" (Credit Received from the Manufacturer for

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a Replaced Medical Device) and will be deducted from the APC payment from the applicable procedure. The OPPS payment deduction for the applicable APCs referenced above will be limited to the total amount of the device offset when the FD value code appears on a claim. The offset amounts for the above referenced APCs, along with the offsets for other APCs, are available under the "Annual Policy Files" link on the left column at http://www.cms.gov/HospitalOutpatientPPS/ on the CMS OPPS website.

CMS is updating the *Medicare Claims Processing Manual* (Chapter 4, Sections 61.3.1 through 61.3.4) and adding Sections 61.3.5 through 61.3.6 to Chapter 4 of that manual to reflect these changes to the reporting guidelines for no cost/full credit and partial credit devices, and these revised and added sections are included as an attachment to CR 8653. Those added sections are as follows:

61.3.5 - Reporting and Charging Requirements When a Device is Furnished Without Cost to the Hospital or When the Hospital Receives a Full or Partial Credit for the Replacement Device Beginning January 1, 2014

Effective January 1, 2014, when a hospital furnishes a new replacement device received without cost or with a credit of 50 percent or more of the cost of a new replacement from a manufacturer, due to warranty, recall, or field action, the hospital must report the amount of the device credit in the amount portion for value code "FD" (Credit Received from the Manufacturer for a Replaced Medical Device). Also effective January 1, 2014, hospitals must report one of the following condition codes when the value code "FD" is present on the claim:

- **49 Product Replacement within Product Lifecycle**—Replacement of a product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly.
- **50 Product Replacement for Known Recall of a Product**—Manufacturer or FDA has identified the product for recall and therefore replacement.

61.3.6 - Medicare Payment Adjustment Beginning January 1, 2014 (Rev. 1657, Issued: 12-31-08, Effective: 01-01-14, Implementation: 01-05-09)

Effective January 1, 2014, Medicare payment is reduced by the amount of the device credit for specified procedure codes reported with value code "FD." The payment deduction is limited to the full device offset when the FD value code appears on a claim. Payment is only reduced for procedure codes that map to the APCs on the list of APCs subject to the adjustment that are reported with value code "FD" and that are present on claims with specified device HCPCS codes.

The OPPS Pricer deducts the lesser of the device credit or the full unadjusted device offset amount from the Medicare payment for a procedure code in an APC subject to the adjustment when billed with value code "FD" on the claim. This deduction is made from the Medicare payment after the multiple procedure discounting and terminated procedure discounting factors are applied, units of service are accounted for, and after the APC payment has been wage adjusted.

When two or more procedures assigned to APCs subject to the adjustment are reported with value code "FD," the OPPS Pricer will apportion the device credit to the applicable line on the claim for each procedure assigned to an APC subject to the adjustment. When value code "FD" is reported on a claim where multiple APCs would be subject to the adjustment, the OPPS Pricer apportions the device credit to each of those lines. The percentage of the device credit apportioned to each applicable line is based on the percentage that the unadjusted payment of each applicable line represents, relative to the total unadjusted payment for all applicable lines.

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Note: The tables of APCs and devices to which the offset reductions apply, and the full and partial offset amounts, are available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html on the CMS website.

New Services

New services listed in Table 1 below, are assigned for payment under the OPPS, effective April 1, 2014.

Table 1 – New Services Payable under OPPS Effective April 1, 2014

HCPCS	Effective date	SI	APC	Short Descriptor	Long descriptor	Payment	Minimum Unadjusted Copayment
C9739	4/01/2014	T	0162	Cystoscopy prostatic imp 1-3	Cystourethroscopy, with insertion of transprostatic implant; 1 to 3 implants	$2,007.32	$401.47
C9740	4/01/2014	T	1564	Cysto impl 4 or more	Cystourethroscopy, with insertion of transprostatic implant; 4 or more implants	$4,750.00	$950.00

Extended Assessment and Management (EAM) Composite APC (8009)

Effective January 1, 2014, CMS will provide payment for all qualifying extended assessment and management encounters through newly created composite APC 8009 (Extended Assessment and Management (EAM) Composite). Any clinic visit, Level 4 or Level 5 Type A Emergency Department (ED) visit, or Level 5 Type B ED visit furnished by a hospital in conjunction with observation services of eight or more hours will qualify for payment through APC 8009. Effective January 1, 2014, CMS will no longer provide payment for extended assessment and management encounters through APCs 8002 (Level I Extended Assessment and Management Composite) and 8003 (Level I Extended Assessment and Management Composite).

CMS is updating the Medicare Claims Processing Manual (Pub. 100-04, Chapter 4, Sections 10.2.1 and 290.5) to reflect these changes to the EAM Composite APC reporting guidelines. These updated sections are included as an attachment to CR 8653.

Billing for Drugs, Biologicals, and Radiopharmaceuticals

a. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective April 1, 2014

In the Calendar Year (CY) 2014 OPPS/ASC final rule with comment period, CMS stated that payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. You can review the CY 2014 OPPS/ASC final rule at http://www.gpo.gov/fdsys/pkg/FR-2013-12-10/pdf/2013-28737.pdf on the Internet. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, CMS will incorporate changes to the payment rates in the April 2014 release of the OPPS Pricer.

The updated payment rates, effective April 1, 2014, will be included in the April 2014 update of the OPPS Addendum A and Addendum B, which will be posted at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html on the CMS website.

b. Drugs and Biologicals with OPPS Pass-Through Status Effective April 1, 2014

Two drugs and biologicals have been granted OPPS pass-through status effective April 1, 2014. These items, along with their descriptors and APC assignments, are identified in Table 2 below.

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Table 2 – Drugs and Biologicals with OPPS Pass-Through Status Effective April 1, 2014				
HCPCS Code	Short Descriptor	Long descriptor	APC	Status Indicator
C9021*	Injection, obinutuzumab, 10 mg	Injection, obinutuzumab	1476	G
Q4121	Theraskin, per square centimeter	Theraskin	1479	G

Note: The HCPCS code identified with an "*" indicates that this is a new code effective April 1, 2014.

c. Revised Status Indicator for HCPCS Codes A9545, J1446, J7178, and Q0181

Effective April 1, 2014, the status indicator for HCPCS code A9545 (Iodine I-131 tositumomab, therapeutic, per treatment dose) will change from SI=K (Paid under OPPS; separate APC payment) to SI=E (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)).

Effective January 1, 2014, the status indicator for HCPCS code J1446 (Injection, TBO-Filgrastim, 5 micrograms) will change from SI=E (not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) to SI=K (Paid under OPPS; separate APC payment).

Effective January 1, 2014, the status indicator for HCPCS code J7178 (Injection, human fibrinogen concentrate, 1 mg) will change from SI=N (Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.) to SI=K (Paid under OPPS; separate APC payment).

Effective January 1, 2014, the status indicator for HCPCS code Q0181 (Unspecified oral dosage form, FDA approved prescription anti-emetic, for use as) will change from SI=E (not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) to SI=N (Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.).

These codes are listed in Table 3 below, along with the effective date for the revised status indicator.

Table 3 – Drugs and Biologicals with Revised Status Indicators				
HCPCS Code	Long Descriptor	APC	Status Indicator	Effective Date
A9545	Iodine I-131 tositumomab, therapeutic, per treatment dose		E	4/1/2014
J1446	Injection, TBO-Filgrastim, 5 micrograms	1477	K	1/1/2014
J7178	Injection, human fibrinogen concentrate, 1 mg	1478	K	1/1/2014
Q0181	Unspecified oral dosage form, FDA approved prescription anti-emetic, for use as		N	1/1/2014

d. Updated Payment Rate for Q4127 Effective April 1, 2013, through June 30, 2013

The payment rate for Q4127 was incorrect in the April 2013 OPPS Pricer. The corrected payment rate is listed in Table 4 below, and it has been installed in the April 2014 OPPS Pricer, effective for services furnished on April 1, 2013 through June 30, 2013. MACs will adjust claims that were previously processed incorrectly if you bring such claims to the attention of your MAC.

Table 4 – Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2013 through June 30, 2013					
HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
Q4127	G	1449	Talymed	$13.78	$2.76

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e. Updated Payment Rate for Q4127 Effective July 1, 2013, through September 30, 2013

The payment rate for Q4127 was incorrect in the July 2013 OPPS Pricer. The corrected payment rate is listed in Table 5 below, and it has been installed in the April 2014 OPPS Pricer, effective for services furnished on July 1, 2013, through September 30, 2013. MACs will adjust claims that were previously processed incorrectly if you bring such claims to the attention of your MAC.

Table 5 – Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2013 through September 30, 2013

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
Q4127	G	1449	Talymed	$13.78	$2.76

f. Updated Payment Rates for Certain HCPCS Codes Effective October 1, 2013 through December 1, 2013

The payment rates for three HCPCS codes were incorrect in the October 2013 OPPS Pricer. The corrected payment rates are listed in Table 6 below, and they have been installed in the April 2014 OPPS Pricer, effective for services furnished on October 1, 2013, through December 31, 2013. MACs will adjust claims that were previously processed incorrectly if you bring such claims to the attention of your MAC.

Table 6 – Updated Payment Rates for Certain HCPCS Codes Effective October 1, 2013 through December 31, 2013

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
A9600	K	0701	Sr89 strontium	$1,196.47	$239.29
J2323	K	9126	Natalizumab injection	$12.99	$2.60
Q4127	G	1449	Talymed	$13.78	$2.76

g. Reassignment of Skin Substitute Products that are New for CY 2014 from the Low Cost Group to the High Cost Group

In the CY 2014 OPPS/ASC final rule, CMS finalized a policy to package payment for skin substitute products into the associated skin substitute application procedure. You can review the CY 2014 OPPS/ASC final rule at http://www.gpo.gov/fdsys/pkg/FR-2013-12-10/pdf/2013-28737.pdf on the Internet. For packaging purposes, CMS created two groups of application procedures: application procedures that use high cost skin substitute products (billed using Current Procedural Terminology (CPT) codes 15271-15278) and application procedures that use low cost skin substitute products (billed using HCPCS codes C5271-C5278). Assignment of skin substitute products to the high cost or low cost groups depended upon a comparison of the July 2013 payment rate for the skin substitute product to $32, which is the weighted average payment per unit for all skin substitute products using the skin substitute utilization from the CY 2012 claims data and the July 2013 payment rate for each product. Skin substitute products with a July 2013 payment rate that was above $32 per square centimeter are paid through the high cost group and those with a July 2013 payment rate that was at or below $32 per square centimeter are paid through the low cost group for CY 2014. As a reminder, for CY 2015, CMS will follow the usual policy with regard to the specific quarterly ASP data sets used for proposed and final rule-making in that CMS will use April 2014 ASP data to establish the proposed rule low/high cost threshold, and CMS will use July 2014 ASP data to establish the final low/high cost threshold for CY 2015.

CMS also finalized a policy that for any new skin substitute products approved for payment during CY 2014, CMS will use the $32 per square centimeter threshold to determine mapping to the high or low cost skin substitute group. Any new skin substitute products without pricing information were assigned to the low cost category until pricing

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information becomes available. There were nine new skin substitute products that were effective January 1, 2014, and that were assigned to the low cost payment group because pricing information was not available for these products at the time of the January 2014 update. There is now pricing information available for three of these nine products. Table 7 below, shows the 3 new products and their low/high cost status based on the comparison of the price per square centimeter for each product to the $32 square centimeter threshold for CY 2014.

Table 7– Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2014

HCPCS Code	Long Descriptor	Status Indicator	Low/High Cost Status
Q4143	Repriza, Per Square Centimeter	N	Low
Q4147	Architect Extracellular Matrix, Per Square Centimeter	N	High
Q4148	Neox 1k, Per Square Centimeter	N	High

h.Billing Guidance for the Topical Application of Mitomycin During or Following Ophthalmic Surgery

Hospital outpatient departments should only bill HCPCS code J7315 (Mitomycin, ophthalmic, 0.2 mg) or HCPCS code J3490 (unclassified drugs) for the topical application of mitomycin during or following ophthalmic surgery. J7315 may be reported only if the hospital uses mitomycin with the trade name Mitosol®. Any other topical mitomycin should be reported with J3490. Hospital outpatient departments are not permitted to bill HCPCS code J9280 (Injection, mitomycin, 5 mg) for the topical application of mitomycin.

New HCPCS Code Effective April 1, 2014

One new HCPCS code has been created for reporting services, supplies, and accessories used in the home under the Medicare intravenous immune globulin (IVIG) demonstration. This code is listed in Table 8 below, and it is effective for services furnished on or after April 1, 2014.

Table 8– New HCPCS Codes Effective April 1, 2014

HCPCS Code	Long Descriptor	Short Descriptor	Status Indicator Effective 4/1/14
Q2052	Services, supplies and accessories used in the home under the Medicare intravenous immune globulin (ivig) demonstration	Ivig demo, services/supplies	N

Changes to OPPS Pricer Logic

Effective January 1, 2014, for claims with APCs, which require implantable devices and have significant device offsets (greater than 40 percent), a device offset cap will be applied to the applicable procedure line based on the credit amount listed in the "FD" (Credit Received from the Manufacturer for a Replaced Medical Device) value code. The credit amount in value code "FD," which reduces the post wage-adjusted APC line payment for the applicable procedure, will be capped by the device offset amount for that APC. The offset amounts for the above referenced APCs, along with the offsets for other APCs, is available under the 'Annual Policy Files' link on the left column at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html on the CMS OPPS website.

Coverage Determinations

The fact that a drug, device, procedure, or service is assigned a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. MACs determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, MACs determine that it is reasonable

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and necessary to treat the beneficiary's condition and whether it is excluded from payment.

Additional Information

The official instruction, CR 8653, issued to your MAC regarding these changes is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2894CP.pdf on the CMS website.

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at **1.866.590.6703** and choose Option 1.

Hospital Information

SE0801 (Revised): Clarification of Patient Discharge Status Codes and Hospital Transfer Policies

The Centers for Medicare & Medicaid Services (CMS) has issued the following revision to the ***Special Edition Medicare Learning Network® (MLN) Matters*** article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2008-MLN-Matters-Articles.html

MLN Matters® Number: SE0801 *Revised*
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Note: This article was revised on March 3, 2014, to add a reference to SE1411 (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1411.pdf). SE1411 was released on March 3, 2014, and supplements SE0801 by providing information on more recently established patient discharge status codes, 69 and 81-95. All other information is the same.

Provider Types Affected

Providers billing Medicare fiscal intermediaries (FIs) or Part A/B Medicare Administrative Contractors (A/B MACs).

Provider Action Needed

STOP – Impact to You

This Special Edition article is based on information from CMS regulations and transmittals and the National Uniform Billing Committee (NUBC) Official UB-04 Data Specifications Manual 2008 (Version 2.00 July 2007) Section Form Locator 17 (Patient Discharge Status) Effective Date: March 1, 2007 copyrighted by the American Hospital Association (AHA); NUBC UB-04 Version 2.00 Clarifications and Errata (as of 8/22/07). It provides clarifications and instructions on determining the correct patient discharge status code to use when completing your claims.

IMPORTANT: The NUBC is responsible for the maintenance and dissemination of guidance for the UB-04 code set. The CMS has provided a subset of information below for Medicare-participating providers. For greater detail, providers should visit http://www.nubc.org/ in order to purchase a UB-04 manual.

CAUTION – What You Need to Know

A patient discharge status code is a two-digit code that identifies where the patient is at the conclusion of a health care facility encounter or at the end time of a billing cycle.

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It belongs in Form Locator 17 on a UB-04 claim form or its electronic equivalent in the HIPAA compliant 837 format.

GO – What You Need to Do

See the "Background" section of this article for more details regarding instructions and clarifications for patient discharge status coding.

Background

This Special Edition article is being provided to help you determine the right discharge status code to use with your claims. Assigning the correct patient discharge status code is just as important as any other coding used when filing a claim and the same processes should be applied for patient discharge status codes as with any other coding. Choosing the patient discharge status code correctly avoids claim errors and helps you receive payment for your claim sooner.

A patient discharge status code is a two-digit code that identifies where the patient is at the conclusion of a health care facility encounter (this could be a visit or an actual inpatient stay) or at the time end of a billing cycle (the 'through' date of a claim). CMS requires patient discharge status codes for:

- Hospital Inpatient Claims (type of bills (TOBs) 11X and 12X);
- Skilled Nursing Claims (TOBs 18X, 21X, 22X and 23X);
- Outpatient Hospital Services (TOBs 13X, 14X, 71X, 73X, 74X, 75X, 76X and 85X); and
- All Hospice and Home Health Claims (TOBs 32X, 33X, 34X, 81X and 82X).

It is important to select the correct patient discharge status code, and in cases in which two or more patient discharge status codes apply, you should code the highest level of care known. Omitting a code or submitting a claim with an incorrect code is a claim billing error and could result in your claim being rejected or your claim being cancelled and payment being taken back. Applying the correct code will help assure that you receive prompt and correct payment.

Identifying the appropriate Patient discharge status Code can sometimes be confusing, so be sure to read the Frequently Asked Questions (FAQ) Section at the end of this article for further guidance.

Patient discharge status Codes and Their Appropriate Use

The following describes patient discharge status codes and provides details regarding their appropriate use:

01- Discharge to Home or Self Care (Routine Discharge)

This code includes discharge to home; jail or law enforcement; home on oxygen if DME only; any other DME only; group home, foster care, and other residential care arrangements; outpatient programs, such as partial hospitalization or outpatient chemical dependency programs; assisted living facilities that are not state-designated.

02 - Discharged/Transferred to a Short-term General Hospital for Inpatient Care

This patient discharge status code should be used when the patient is discharged or transferred to a short-term acute care hospital. Discharges or transfers to long-term care hospitals should be coded with Patient discharge status Code 63.

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03 - Discharged/Transferred to a Skilled Nursing Facility (SNF) with Medicare Certification in Anticipation of Skilled Care.

This code indicates that the patient is discharged/transferred to a Medicare certified nursing facility in anticipation of skilled care. For hospitals with an approved swing bed arrangement, use Code 61- Swing Bed.

This code should be used regardless of whether or not the patient has skilled benefit days and regardless of whether the transferring hospital anticipates that this SNF stay will be covered by Medicare. For reporting other discharges/transfers to nursing facilities see codes 04 and 64.

Code 03 should **not** be used if:

- The patient is admitted to a non-Medicare certified area.

04 - Discharged/Transferred to an Intermediate Care Facility (ICF)

Patient discharge status code 04 is typically defined at the state level for specifically designated intermediate care facilities. It is also used:

- To designate patients that are discharged/transferred to a nursing facility with neither Medicare nor Medicaid certification, or
- For discharges/transfers to state designated Assisted Living Facilities.

05 - Discharged/Transferred to Another Type of Health Care Institution Not Defined Elsewhere in This Code List

Cancer hospitals excluded from Medicare PPS and children's hospitals are examples of such other types of health care institutions.

NEW DEFINITION FOR PATIENT DISCHARGE STATUS CODE 05- Effective, per NUBC, on April 1, 2008

05 - Discharged/Transferred to a Designated Cancer Center or Children's Hospital

Usage Note: Transfers to non-designated cancer hospitals should use Code 02. A list of (National Cancer Institute) Designated Cancer Centers can be found at http://cancercenters.cancer.gov/cancer_centers/ on the Internet.

06 - Discharged/Transferred to Home Under Care of Organized Home Health Service Organization in Anticipation of Covered Skilled Care

This code should be reported when a patient is:

- Discharged/transferred to home with a written plan of care for home care services (tailored to the patient's medical needs) — whether home attendant, nursing aides, certified attendants, etc.
- Discharged/transferred to a foster care facility with home care; and
- Discharged to home under a home health agency with DME.

This code should **not** be used for home health services provided by a:

- DME supplier or
- Home IV provider for home IV services.

07 - Left Against Medical Advice or Discontinued Care

The important thing to remember about this patient discharge status code is that it is to be used when a patient leaves against medical advice or the care is discontinued. According to the NUBC, discontinued services may include:

- Patients who leave before triage, or are triaged and leave without being seen by a physician; or

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- Patients who move without notice, and the home health agency is unable to complete the plan of care.

08 - Reserved for National Assignment

This patient discharge status code is reserved for national assignment.

09 - Admitted as an Inpatient to this Hospital

This code is for use only on Medicare outpatient claims, and it applies only to those Medicare outpatient services that begin greater than three days prior to an admission.

10-19 - Reserved for National Assignment

These patient discharge status codes are reserved for national assignment.

20 - Expired

This code is used only when the patient dies.

21-29 - Reserved for National Assignment

These patient discharge status codes are reserved for national assignment.

30 - Still Patient or Expected to Return for Outpatient Services

This code is used when the patient is still within the same facility and is typically used when billing for leave of absence days or interim bills. It can be used for both inpatient or outpatient claims.

It is used for inpatient claims when billing for leave of absence days or interim billing (i.e., the length of stay is longer than 60 days).

On outpatient claims, the primary method to identify that the patient is still receiving care is the bill type frequency code (e.g., Frequency Code 3: Interim - Continuing Claim).

31-39 - Reserved for National Assignment

These patient discharge status codes are reserved for national assignment.

Hospice Patient discharge status Codes - Hospice Claims Only (TOBs: 81X & 82X)

The following patient discharge status codes should only be used when submitting hospice claims:

- **40** - Expired at Home; This code is for use only on Medicare and TRICARE claims for hospice care.
- **41** - Expired in a Medical Facility, such as a Hospital, Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF), or Free-standing Hospice; and
- **42** - Expired - Place Unknown; This code is for use only on Medicare and TRICARE claims for hospice care

43 - Discharged/Transferred to a Federal Hospital

This code applies to discharges and transfers to a government operated health care facility including:

- Department of Defense hospitals;
- Veteran's Administration hospitals; or
- Veteran's Administration nursing facilities.

This patient discharge status code should be used whenever the destination at discharge is a federal health care facility, whether the patient resides there or not.

The NUBC has also clarified that this code should also be used when a patient is transferred to an inpatient psychiatric unit of a Veterans Administration (VA) hospital.

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44-49 Reserved for National Assignment

These patient discharge status codes are reserved for national assignment.

50 and 51 - Discharged/Transferred to a Hospice

These two patient discharge status codes are used to identify when a patient is discharged or transferred to hospice care.

The level of care that will be provided by the hospice upon discharge is essential to determining the proper code to use. NUBC clarified the following Hospice Levels of Care:

- Routine or Continuous Home Care. Patient discharge status **code "50**: Hospice home" should be used if the patient went to his/her own home or an alternative setting that is the patient's "home," such as a nursing facility, and will receive in-home hospice services.
- General Inpatient Care. Patient discharge status **code "51** Hospice medical facility" should be used if the patient went to an inpatient facility that is qualified and the patient is to receive the general inpatient hospice level of care.
- Inpatient Respite. Patient discharge status **code "51** Hospice medical facility" should be used if the patient went to a facility that is qualified and the patient is receiving hospice inpatient respite level of care. Unless a patient has already been admitted to/accepted by a hospice, level of care can not be determined. Therefore, it is recommended that, if a patient is going home or to an institutional setting with a hospice "referral only," (without having already been accepted for hospice care by a hospice organization) the patient discharge status code should simply reflect the site to which the patient was discharged, not hospice (**i.e. 01: home or self care, or 04**: an intermediate care nursing facility, assuming it is not a Medicare SNF admission).

Additional Guidance on Use of Patient discharge status Code 50 or 51:

- Patient discharge status Code 50 should be used if the patient went to his/her own home or an alternative setting that is the patient's "home," such as a nursing facility, and will receive in-home hospice services.

Patient discharge status Code 51 should be used when a patient is:

- Discharged from acute hospital care but remains at the same hospital under hospice care,
- Transferred from an inpatient acute care hospital to a Medicare-certified SNF under the following conditions:
  - The patient has elected the hospice benefit and will be receiving hospice care under arrangement with a hospice organization; the patient is receiving residential care only.
  - The patient does not qualify for skilled level of care outside the hospice benefit for conditions unrelated to the terminal illness.
  - Admitted from home (a private residence) to an acute setting. Upon discharge, the patient is transferred as a new nursing home placement to a designated hospice unit/bed.

52-60 - Reserved for National Assignment

These patient discharge status codes are reserved for national assignment.

61 - Discharged/Transferred to a Hospital-based Medicare Approved Swing Bed

This code is used for reporting patients discharged/transferred to a SNF level of care within the hospital's approved swing bed arrangement.

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When a patient is discharged from an acute hospital to a Critical Access Hospital (CAH) swing bed, use Patient discharge status Code 61. Swing beds are not part of the post acute care transfer policy.

62 - Discharged/Transferred to an Inpatient Rehabilitation Facility Including Distinct Part Units of a Hospital

Inpatient rehabilitation facilities (or designated units) are those facilities that meet a specific requirement that 75% of their patients require intensive rehabilitative services for the treatment of certain medical conditions. This code should be used when a patient is transferred to a facility or designated unit that meets this qualification.

63 - Discharged/Transferred to Long Term Care Hospitals

This code is for hospitals that meet the Medicare criteria for LTCH certification as follows: Long term care hospitals are facilities that provide acute inpatient care with an average length of stay of 25 days or greater. This code should be used when transferring a patient to a long term care hospital. If you are not sure whether a facility is a long term care hospital or a short term care hospital, you should contact the facility to verify their facility type before assigning a patient discharge status code.

64 - Discharged/Transferred to a Nursing Facility Certified Under Medicaid but not Certified Under Medicare

Nursing facilities may elect to certify only a portion of their beds under Medicare, and some nursing facilities choose to certify all of their beds under Medicare. Still others elect not to certify any of their beds under Medicare. When a patient is transferred to a nursing facility that has no Medicare certified beds, this code should be used. If any beds at the facility are Medicare certified, then the provider should use either Patient discharge status Code 03 or 04, depending on:

- The level of care the patient is receiving; and
- Whether the bed is Medicare certified or not.

65 - Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital

This code should be used when a patient is transferred to an inpatient psychiatric unit or inpatient psychiatric designated unit.

Note: This code should not be used when a patient is transferred to an inpatient psychiatric unit of a federal hospital (e.g. Veterans Administration Hospitals). In this case, see Patient discharge status Code 43.

66 - Discharged/Transferred to a Critical Access Hospital (CAH)

Patient discharge status Code 66 is used to identify a transfer to a critical access hospital (CAH) for inpatient care. Providers will need to establish a process for identifying whether a hospital is paid under the prospective payment system (PPS) or whether the facility is designated as a CAH.

Note: Discharges or transfers to a critical access hospital (CAH) swing bed should still be coded with Patient discharge status Code 61.

67-69 - Reserved for National Assignment

These patient discharge status codes are reserved for national assignment.

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NEW PATIENT DISCHARGE STATUS CODE 70 – Per NUBC, Effective April 1, 2008:

70 – Discharged/transferred to another Type of Health Care Institution not Defined Elsewhere in this Code List

New patient discharge status code 70 was created in order for providers to be able to indicate discharges/transfers to another type of health care institution not defined elsewhere in the code list. This code is effective for use by providers for discharges/to dates on or after April 1, 2008. (See Code 05)

71-99 - Reserved for National Assignment

These patient discharge status codes are reserved for national assignment.

Patient Discharge Status Codes Affected by the Hospital Transfer Policies for Inpatient PPS and IRF PPS

The IPPS Acute to Acute Transfer policy applies to transfers coded with patient discharge status code 02 and applies to ALL DRGs and when the length of stay is less than the average length of stay for the DRG.

Under **Medicare's Post Acute Care Transfer policy** (42 CFR 412.4), a discharge of a hospital inpatient is considered to be a post acute care transfer when the patient's discharge is assigned to one of the qualifying diagnosis-related groups (DRGs), and the discharge is made under any of the following circumstances:

- To a hospital or distinct part hospital unit excluded from the inpatient prospective payment system (IPPS) (includes: Inpatient Rehabilitation Facilities, Long Term Care Hospitals, psychiatric hospitals, cancer hospitals and children's hospitals);
- To a skilled nursing facility (not swing beds); and
- To home under a written plan of care for the provision of home health services from a home health agency and those services begin within 3 days after the date of discharge.

Note: A list of the FY2008 DRGs is available in Table 5 of the IPPS final rule for 2008. That table is available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Acute-Inpatient-Files-for-Download-Items/CMS1247844.html on the CMS website.

Based on the above, the IPPS Post-Acute Care Transfer Policy applies to claims coded with Patient discharge status Codes 03, 05, 06, 62, 63, and 65.

Inpatient Rehabilitation Facilities (IRFs): 42 CFR 412.624(f) The following Patient discharge status Codes are applicable under the IRF Transfer Policy for IRF PPS: 02, 03, 61, 62, 63, and 64.

NUBC Frequently Asked Questions (FAQs) and Answers

1. Q: A patient is discharged from our facility (disposition **code 01**) and is to go to a doctor's appointment the same day. The patient is then admitted to another hospital after seeing the doctor. What disposition code is appropriate, **01 or 02**?

   *A: Based on the information the hospital had at discharge, the patient was discharged to **home (01). If your facility was unaware of the planned admission at the second facility, it is likely that you will have to modify/adjust your previously submitted claim to indicate a disposition code 02, which reflects where the patient was later admitted on the same date.***

2. Q: If a facility discharges a patient to a personal care home, which is similar to assisted living facilities, are they most appropriately **coded as 01 or 04**?

   *A: If the personal care home is the person's place of residence, even temporarily, use **Code 01**, discharged to home or self care.*

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3. Q: What discharge status code should be used when a patient is sent to another acute care facility for an outpatient procedure later in the day? This occurs when we do not have the equipment to perform the procedure and the intention is that the patient will not be returning to our facility after the procedure.

   *A: Since this is a discharge to outpatient treatment, and it is expected that the patient will go home afterward, use discharge **status 01**, discharged to home or self care.*

4. Q: We have a Home Health Agency with DME. Often we find the orders reads "Home with Walker". We do not see a physician order for home health care nor has there been an assessment documented by the receiving home health nurse. The nursing discharges instructions check "home". Is the Patient discharge status **Code still 06**?

   *A: No. "Home with Walker" does not imply a discharge to home under care of organized home health service organization in anticipation of covered skilled care. Accordingly, **Code 01**, discharged to home or self care (routine discharge) would be appropriate.*

5. Q: What is the difference between residential care and assisted living care?

   *A: In terms of patient discharge status codes, there is no difference. Discharges to residential care and private (non-state designated/supported) assisted living facilities are coded alike **(01)**.*

6. Q: An established nursing home patient (i.e. the nursing home is their permanent residence) is transferred to an acute setting. Upon discharge, they are sent back to the same nursing home with a hospice referral only. What patient discharge status code would be appropriate?

   *A: If the patient has not made a hospice election, and has a referral only, use **Code 01**, Discharged to Home.*

7. Q: A patient was discharged to home with home health services. Two days later the patient was readmitted to our hospital. We were notified by the discharge planner of the patient's readmission and the fact that home health services were not started for the patient and the discharge status code needed to be changed to 01. By the time of the discharge planner's notification, we had already submitted the patient's bill with the discharge status code of 06. In this instance what should the correct discharge status code be on this patient?

   *A: To ensure accurate reimbursement and reporting, send a replacement claim with the correct discharge status **code (01)**.*

8. Q: What status code should be used for a patient transferred to a SNF rehabilitation unit? This unit is within the SNF. Is this considered a transfer to a SNF or to a rehabilitation facility?

   *A: A rehabilitation unit that is part of a skilled nursing facility is paid under the SNF prospective payment system. Moving a patient from one unit to another does not constitute a transfer for billing purposes and should not result in separate claims. If a patient is discharged from an acute inpatient hospital to a Medicare-certified SNF in anticipation of skilled care, **use 03**. Status **code 03** is also used if the patient moves from an acute inpatient hospital to a rehab unit in a SNF.*

9. Q: What is the appropriate patient discharge status code for a patient transferred from an acute care hospital to a nursing facility for a non-skilled/custodial/ residential level of care? For example:

   The patient is discharged to a facility that is only certified with skilled beds but the patient does not qualify for a skilled level of care.

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The Medicare certified nursing facility is licensed for both skilled and intermediate care beds, and the patient is transferred to intermediate care.

The patient resides at a Medicare certified SNF but only receives non-skilled services.

*A: **Code 04**, discharged/transferred to an intermediate care facility (ICF) would be the appropriate patient status discharge code for all of the examples above.*

10. Q: If a patient is discharged from a hospital based Transitional Care Unit (i.e., skilled nursing unit) to the acute hospital under Observation Status, what is the Discharge Status for the TCU claim?

    *A: Use **Code 05**, discharged/transferred to another type of health care institution not defined elsewhere in this code list.*

11. Q: If a patient is discharged to home for the provision of home health services, but, the continuing care is either 1) not related to the condition or diagnosis for which the individual received inpatient hospital services or 2) is related, but, not provided within the post-discharge window, what is the correct patient status code to use?

    *A: **Code 06** would be the appropriate patient discharge status code. In addition, the provider should append one of the following condition codes, as appropriate, to the claim:*

    - ***Condition Code 42** – Continuing care not related (i.e. condition or diagnosis) to inpatient admission or;*
    - ***Condition Code 43** – Continuing care not provided within prescribed post-discharge window.*

12. Q: If a patient is discharged from an acute care hospital and PT/OT is arranged to be done in the home by a rehabilitation agency that is not affiliated with the home health care agency that made the arrangements, what is the appropriate code to use — 01 or 06?

    *A: If the therapy services are being provided under the home health benefit (e.g. Medicare Part A), **use Code 06**; if the therapy is provided under the outpatient therapy benefit (e.g., Medicare Part B), **use Code 01**.*

13. Q: If a patient is discharged from acute hospital care but remains at the same hospital under hospice care, what status code should be used for the acute stay discharge?

    *A: **Use Code 51** Hospice - medical facility*

14. Q: What discharge status code should be used when a patient is discharged to a chemical dependency treatment facility that is not part of a hospital?

    *A: If the chemical dependency treatment facility is not a psychiatric hospital or psychiatric distinct part unit of a hospital, and the patient is undergoing inpatient/ residential treatment, use Code 05, discharged/transferred to another type of health care institution not defined elsewhere in this code list. **(Note: The NUBC has approved the establishment of a new code (70) to take effect April 1, 2008 for other types of health care facilities not defined elsewhere in the code list.)**.*

Additional Information

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at **1.866.590.6703** and choose Option 1.

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Hospital Information

SE1401: Point of Origin for Admission or Visit Code (Formerly Source of Admission Code) for Inpatient Psychiatric Facilities (IPFs)

The Centers for Medicare & Medicaid Services (CMS) has issued the following ***Special Edition Medicare Learning Network® (MLN) Matters*** article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2014-MLN-Matters-Articles.html

MLN Matters® Number: SE1401
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected

This MLN Matters® Special Edition article is intended for inpatient psychiatric facilities (IPFs) submitting claims to Part A/B Medicare administrative contractors (A/B MACs) that involve inpatient transfers within the same facility.

What You Need to Know

Recovery Auditors have conducted reviews of Medicare Prospective Payment System (PPS) claims for inpatient psychiatric facilities (IPF) services. These reviews have identified a substantial number of overpayments for inpatient psychiatric services directly following an acute care stay within the same facility. These errors and overpayments occurred because the Source of Admission Code 'D' was not applied to those claims. The Point of Origin for Admission or Visit Code "D" (formerly the Source of Admission Code) must be used when a patient is discharged from an acute-care stay in a hospital and transferred to the same hospital's inpatient psychiatric Distinct Part Unit (DPU).

Under the Medicare PPS, the Centers for Medicare & Medicaid Services (CMS) makes an additional payment to an IPF or a DPU for the first day of a beneficiary's stay to account for emergency department costs if the IPF has a qualifying emergency department. However, CMS does not make this payment if the beneficiary was discharged from an acute-care stay and transferred to its own hospital based IPF since payment for the emergency department services are included in the Medicare payment for the acute-care stay. The Point of Origin for Admission or Visit Code "D" prevents this overpayment.

The correct Point of Origin for Admission or Visit code (formerly Source of Admission) must be applied to prevent incorrect payments.

Case Studies

Example 1: On January 10, 2010, an 85 year old female is admitted through the Emergency Room for a one day stay in an acute-care inpatient hospital setting. On January 11, 2010, the patient is admitted to the inpatient psychiatric unit of the same facility. The claim for this admission was submitted with Point of Origin for Admission or Visit Code "1" (Physician Referral).

Resolution: Because the January 11th admission was a transfer from the same facility, the Point of Origin for Admission or Visit Code should be coded "D". The incorrect Source of Admission Code resulted in an overpayment of $105.06.

Example 2: On January 19, 2012, a 63 year old male is admitted through the Emergency Room for a two day stay in an acute-care inpatient hospital setting. On January 21, 2012,

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the patient is admitted to the inpatient psychiatric unit of the same facility. The claim for this admission was submitted with Point of Origin for Admission or Visit Code "2" (Clinic Referral).

Resolution: Because the January 21st admission was a transfer from the same facility, the Point of Origin for Admission or Visit Code should be coded "D". The incorrect Source of Admission Code resulted in an overpayment of $98.15.

Additional Information

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at **1.866.590.6703** and choose Option 1.

For more information about IPFs and use of Point of Origin for Admission or Visit Code D, see the MLN Matters® article SE1020 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1020.pdf on the CMS website.

MM3881 also provides additional information about Point of Origin for Admission or Visit Code 'D' at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM3881.pdf on the CMS website.

To review the **Inpatient Psychiatric Facility Prospective Payment System** Fact Sheet that provides detailed information about the background, coverage requirements, payment rates, Fiscal Year (FY) 2013 updates to the IPF PPS, quality reporting, and resources; visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/InpatientPsychFac.pdf on the CMS website.

Hospital Information

SE1412: Update to 2014 Hospital Outpatient Clinical Diagnostic Laboratory Test Payment and Billing

The Centers for Medicare & Medicaid Services (CMS) has issued the following ***Special Edition Medicare Learning Network® (MLN) Matters*** article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2014-MLN-Matters-Articles.html

MLN Matters® Number: SE1412
Related CR Release Date: December 27, 2013
Related CR Transmittal #: R2845CP
Related Change Request (CR) #: 8572
Effective Date: January 1, 2014
Implementation Date: January 6, 2014

Provider Types Affected

This MLN Matters® Special Edition article is intended for Outpatient Prospective Payment System (OPPS) providers submitting claims to A/B Medicare administrative contractors (MACs) for outpatient clinical diagnostic laboratory services to Medicare beneficiaries.

What You Need to Know

This article conveys updated requirements for CR 8572 which describes changes to the OPPS to be implemented in the January 2014 update. Make sure your billing staff is aware of these changes. This guidance updates the operational mechanism OPPS hospitals should use to bill Medicare on or after July 1, 2014, for outpatient clinical diagnostic laboratory tests (lab tests) furnished in CY 2014 that are eligible for separate payment under the Clinical Laboratory Fee Schedule (CLFS).

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Background

In the January 2014 update to the hospital OPPS (CR 8572 issued December 27, 2013), CMS implemented a new policy under the CY 2014 OPPS final rule, providing packaged payment of outpatient lab tests (other than molecular pathology) under the OPPS rather than separate CLFS payment, effective for dates of service on or after January 1, 2014. In the Medicare claims system, packaged payment would apply to all lab tests (other than molecular pathology) billed by OPPS hospitals on a 013X Type of Bill (TOB) (Hospital Outpatient).

As per the OPPS final rule, CMS created very limited exceptions to the packaging policy and instructed hospitals to use the 014X TOB (Hospital Non-Patient) to obtain separate payment only in the following circumstances:

1. Non-patient (referred) specimen;
2. A hospital collects specimen and furnishes only the outpatient labs on a given date of service; or
3. A hospital conducts outpatient lab tests that are clinically unrelated to other hospital outpatient services furnished the same day. “Unrelated” means the laboratory test is ordered by a different practitioner than the practitioner who ordered the other hospital outpatient services, for a different diagnosis.

In accordance with Medicare manual instructions, CMS assumed that a hospital functions as an independent laboratory in these circumstances. Therefore, hospitals could use the 014x bill used for “non-patients.” In the absence of public comments indicating otherwise, CMS believed this was an appropriate use of the 014x TOB.

Since publication of the final rule and the January release of CR 8572, some hospitals expressed concern that submitting a 014x TOB in this manner may violate the Health Insurance Portability and Accountability Act. **The National Uniform Billing Committee (NUBC) definition approved in 2005 for the 014x TOB for billing of laboratory services provided to “Non-Patients,” means referred specimen, where the patient is not present at the hospital.**

To alleviate this concern, for CY 2014 a new modifier will be used on the 013X TOB (instead of the 014X TOB) when non-referred lab tests are eligible for separate payment under the CLFS for exceptions (2) and (3) listed above. The 014x will only be used for non-patient (meaning referred) laboratory specimens (exception 1 above) and will not include this new modifier. The new modifier will be effective for claims received on or after July 1, 2014, and retroactive for dates of service on or after January 1, 2014. Please note that CMS views this new modifier as an immediate solution to hospitals’ concern for CY 2014 and that we may evaluate better means to bill for laboratory services next year.

Additionally to alleviate concerns on what hospitals can do in the interim period until the new modifier is implemented on July 1, 2014, CMS, **at the request of the NUBC**, will continue to allow providers to utilize the 014x TOB during this interim period when a hospital seeks separate payment under any of the three exceptions listed above, as per the CY 2014 OPPS final rule. This will allow time for providers to make necessary system adjustments without having to hold claims until the July implementation.

It will continue to be the hospital’s responsibility to determine when laboratory tests qualify to receive separate payment. Starting with claims received July 1, 2014, and after, when a hospital appends the new modifier to a laboratory service, the provider is attesting that exception (2) or (3) listed above is met. The requirement for all OPPS services to be submitted on a single 13x claim (other than recurring services) continues to apply. In addition, laboratory tests for molecular pathology tests described by CPT codes in the ranges of 81200 through 81383, 81400 through 81408, and 81479 are not packaged in the OPPS and do not require the new modifier.

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Note: Under the CY 2014 OPPS final rule, it is optional for OPPS hospitals to seek separate payment under the CLFS for a given outpatient lab test. To minimize administrative burden, OPPS hospitals are not required to distinguish related and unrelated outpatient lab tests, and may bill "unrelated" outpatient labs on the 013X TOB prior to July 1, 2014, or on the 013X TOB without the new modifier on or after July 1, 2014, to receive packaged payment under the OPPS. Hospitals are not required to reprocess any previously submitted claims.

The table below summarizes the billing discussed above.

Condition	Claims with Dates of Service on or after January 1, 2014, and received Prior to July 1, 2014	Claims with Dates of Service on or after January 1, 2014 Received on or after July 1, 2014
(1) Non-patient (referred) specimen;	TOB 14x	TOB 14x without the new modifier
(2) A hospital collects specimen and furnishes only the outpatient labs on a given date of service;	*TOB 14x	TOB 13x and the new modifier, effective January 1, 2014
(3) A hospital conducts outpatient lab tests that are clinically **unrelated** to other hospital outpatient services furnished the same day	*TOB 14x	TOB 13x and the new modifier, effective January 1, 2014

* The 014X TOB does not provide differential CLFS payment rates for SCHs with qualified laboratories and other OPPS hospitals. See section below for further details.

Sole Community Hospitals (SCHs)

SCHs are paid under the OPPS. Therefore, the new OPPS packaging policies apply to SCHs as to other OPPS hospitals for laboratory and other services furnished on or after January 1, 2014. However, SCHs with qualified laboratories continue to be eligible for the 62 percent CLFS payment amount described in the Medicare Claims Processing Manual (Pub. 100-04 Chapter 16, Section 40.3) when they furnish outpatient lab tests that are separately payable under exceptions (2) or (3) listed above. The 014X TOB does not provide differential CLFS payment rates for SCHs with qualified laboratories and other OPPS hospitals. Qualified SCHs must submit a 013X TOB with the new modifier appended to separately payable outpatient lab services in order to obtain the 62 percent CLFS payment amount provided in current manual instructions. CMS recognizes that these providers may wish to cancel or adjust claims that are submitted without the new modifier prior to July 1, 2014, and submit a new 013x claim with the appended modifier after July 1, 2014, in order to receive corrected reimbursement or for other reasons when the new modifier is implemented in July.

CMS will be reviewing claims data for CY 2014 for potential inappropriate unbundling of laboratory services under the new OPPS packaging policy. As stated in the OPPS final rule, CMS does not expect changes in practice patterns under the new policy. Hospitals may not establish new scheduling patterns in order to provide laboratory services on separate dates of service from other hospital services for the purpose of receiving separate payment under the CLFS.

Billing Scenarios for the New Modifier (on or after July 1, 2014):

1. A patient goes to hospital and the hospital only collects the specimen and furnishes only laboratory services on that date of service. No other services are rendered on this date of service. It is generally appropriate to append the new modifier to the laboratory services (see example 2).
2. A beneficiary has a pre-surgery exam in a provider-based clinic for an outpatient cataract surgery that is scheduled in two weeks with the ophthalmologist. On the same day, while at the hospital the beneficiary goes to the hospital lab to have blood drawn for long-term psychiatric medication monitoring, by order of a community psychiatrist. In this situation, the hospital can use the new modifier to bill Medicare for separate payment under the CLFS of the lab test to monitor the

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patient's psychiatric medication level. However, any lab tests run by the hospital lab that day upon the order of the ophthalmologist or another physician in the ophthalmologist's group practice in preparation for the cataract surgery cannot be billed for separate payment.

3. The beneficiary in example 2 goes to the hospital lab to have blood drawn for long-term psychiatric medication monitoring, by order of a community psychiatrist, and has no other hospital services that day. The hospital can use the new modifier to bill Medicare for separate payment under the CLFS of the lab test to monitor the patient's psychiatric medication level.
4. The beneficiary in example 2 has the pre-surgery exam in the ophthalmologist's free-standing physician office. The ophthalmologist refers the beneficiary to the hospital lab located across the street for diagnostic lab tests in preparation for the upcoming outpatient surgery. The beneficiary has to immediately return to work and chooses to have the lab work done at the hospital 2 days later. The hospital can use the new modifier to bill Medicare for separate payment under the CLFS.
5. The beneficiary in example 3 goes to the hospital lab the same day to have the pre-surgical labs drawn. The hospital can use the new modifier to bill Medicare for separate payment under the CLFS.

As a reminder, for claims received on or after July 1, 2014, OPPS providers are instructed to submit "specimen only" services on the 014x TOB. OPPS providers are instructed not to use the new modifier on 014x TOB.

Additional Information

To read the article related to CR 8572, go to http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8572.pdf on the CMS website.

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at **1.866.590.6703** and choose Option 1.

ICD-10 Information

MM8465 (Revised): International Classification of Diseases, 10th Revision (ICD-10) Testing with Providers through the Common Edits and Enhancements Module (CEM) and Common Electronic Data Interchange (CEDI)

The Centers for Medicare & Medicaid Services (CMS) has issued a revision to the following ***Medicare Learning Network® (MLN) Matters*** article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2014-MLN-Matters-Articles.html

MLN Matters® Number: MM8465 *Revised*
Related CR Release Date: February 26, 2014
Related CR Transmittal #: R1353OTN
Related Change Request (CR) #: CR 8465
Effective Date: December 3, 2013
Implementation Date: March 3, 2014;

Note: This article was revised on February 27, 2014, to reflect a revised CR that provides additional information to providers, suppliers, and clearinghouses about how claims will be submitted for testing (page 2 in bold). The transmittal number, CR release date and link to the CR were also changed. All other information remains the same.

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Provider Types Affected

This MLN Matters® article is intended for Medicare providers and suppliers submitting claims to Medicare contractors (A/B Medicare administrative contractors (A/B MACs), home health and hospice MACs (HHH MACs) and the durable medical equipment MACs (DME MACs) for services to Medicare beneficiaries.

What Providers Need to Know

This article is based on CR 8465, which announces plans for front-end ICD-10 testing between MACs and their trading partners.

For dates of service of October 1, 2014, (and after) providers are required to submit ICD-10 codes on their claims. MACs must provide the opportunity for providers and suppliers to submit test claims through the CEM or the CEDI on the designated testing days.

- **Test claims with ICD-10 codes must be submitted with current dates of service (i.e. October 1, 2013, through March 3, 2014), since testing does not support future dated claims.**
- **Test claims will receive the 277CA or 999 acknowledgement as appropriate, to confirm that the claim was accepted or rejected in the system.**
- **Testing will not confirm claim payment or produce remittance advice.**
- **MACs and CEDI will be staffed to handle increased call volume during this week.**

Make sure that your billing staff is aware of these upcoming ICD-10 testing periods.

Background

CMS is in the process of implementing ICD-10. All covered entities have to be fully compliant on October 1, 2014.

CR 8465 instructs all Medicare MACs and the DME MACs CEDI contractor to implement an ICD-10 testing week with trading partners. The concept of trading partner testing was originally designed to validate the trading partners' ability to meet technical compliance and performance processing standards during the HIPAA 5010 implementation. The ICD-10 testing week has been created to generate awareness and interest and to instill confidence in the provider community that CMS and the MACs are ready and prepared for the ICD-10 implementation.

This testing week will give trading partners access to the MACs and CEDI for testing with real-time help desk support. The event will be conducted virtually and will be posted on each MAC and the CEDI website as well as the CMS website.

The testing week will be March 3 through March 7, 2014.

Testing Week Information:

- Your MAC will announce and actively promote the testing week via ListServ messages and will post the testing week announcement on their website.
- Your MAC will host a registration site for the testing week, or provide an e-mail address for the trading partners to provide registration information. The registration site or e-mail address information will be available and publicized to trading partners at least four weeks prior to the testing week.
- During the testing week, EDI help desk support will be available, at a minimum, from 9:00 a.m. to 4:00 p.m. local contractor time, with enough support to handle any increased call volume.

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- Providers and suppliers participating during the testing week will receive electronic acknowledgement confirming that the submitted test claims were accepted or rejected.
- On or before March 18, 2014, your contractor will report the following to CMS:
  - Number of trading partners conducting testing during the testing week.
  - Percent of trading partners that conducted testing during the testing week (versus number of trading partners supported) by contract.
  - Percent of test claims accepted versus rejected.
  - Report of any significant issues found during testing.

Additional Information

The official instruction, CR 8465, issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1353OTN.pdf on the CMS website.

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at **1.866.590.6703** and choose Option 1.

ICD-10 Information

MM8602: International Classification of Diseases, Tenth Revision (ICD-10) Limited End to End Testing with Submitters

The Centers for Medicare & Medicaid Services (CMS) has issued the following ***Medicare Learning Network® (MLN) Matters*** article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2014-MLN-Matters-Articles.html

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Related CR Transmittal #: R1352OTN
Related Change Request (CR) #: CR 8602
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Provider Types Affected

This MLN Matters® article is intended for physicians, other providers, and suppliers who submit claims to Medicare claims administration contractors (durable medical equipment Medicare administrative contractors (DME MACs), A/B Medicare administrative contractors (A/B MACs), and/or home health and hospices (HH & H MACs) for services provided to Medicare beneficiaries.

What You Need to Know

This article is based on CR 8602 which instructs providers and clearinghouses on how to volunteer to be chosen for ICD-10 End to End testing with Medicare in July 2014. Potential testers must complete the volunteer form on the MAC website by March 24, 2014.

Background

The International Classification of Disease, Tenth Revision, (ICD-10) must be implemented by October 1, 2014. While system changes to implement this project have been completed and tested in previous releases, the industry has requested the opportunity to test with CMS.

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CR 8602 will allow for a small subset of Medicare claims submitters to test with MACs and the Common Electronic Data Interchange (CEDI) contractor to demonstrate that CMS systems are ready for the ICD-10 implementation. This additional testing effort will further ensure a successful transition to ICD-10.

To facilitate this testing, CR 8602 requires MACs to do the following:

- Conduct a limited end to end testing with submitters in July 2014. Test claims will be submitted July 21-25, 2014.
- Each MAC (and CEDI with assistance from DME MACs) will select 32 submitters to participate in the end-to-end testing. The Railroad Retirement Board (RRB) contractor will select 16 submitters. Testers will be selected randomly from a list of volunteers. At least five, but not more than ten of the testers will be a clearinghouse, and submitters should be a mix of provider types.
- By March 7, 2014, the MACs and CEDI will post a volunteer form to their website to collect volunteer information with which to select volunteers. The form will provide information to verify that volunteers are ready to test, meet the requirements to test, and collect needed data about the tester (how they submit claims, what type of claims will be tested, etc.). Volunteers must submit the completed forms to the MACs and CEDI by March 24, 2014.
- By April 14, 2014, the MACs and CEDI (for the DME MACs) will notify the volunteers that they have been selected to test and provide them with the information needed for the testing, such as:
  - How to submit test claims (for example, what test indicators should be set);
  - What dates of service may be used for testing;
  - How many claims may be submitted for testing (Test claims volume is limited to a total of 50 claims for the entire testing week, submitted in no more than three files);
  - Request for National Provider Identifiers (NPIs) and Health Insurance Claim Numbers (HICNs) that will be used in testing (no more than 5 NPIs and 10 HICNs per submitter);
  - Notice that if more than 50 claims are submitted, they may not be processed;
  - Notice that claims submitted with NPIs or HICNs not previously submitted for testing, likely will not be completed; and
  - Notice of potential Protected Health Information (PHI) on test remittances not submitted (and instructions to report PHI found to the MAC).
- MACs and CEDI (for the DME MACs) will collect information from the selected test volunteers to request the HICNs, NPIs, and Provider Transaction Access Numbers (PTANs) the testers will use during the testing. The forms for this information must be completed and returned to the MAC/CEDI by May 2, 2014. If these forms are not returned by May 2, the tester may lose the opportunity to test.
- CEDI will instruct suppliers to submit claims with ICD-10 codes with Dates of Service (DOS) 10/1/2014 through 10/15/2014. They may also submit claims with ICD-9 codes with DOS before 10/1/2014.
- MACs will instruct testers to submit test claims with ICD-10 codes with DOS on or after 10/1/2014. They may also submit test claims with ICD-9 codes with DOS before 10/1/2014.
- MACs and CEDI will be prepared to support increased call volume from testers during the testing window, and up to 2 weeks following the receipt of the Electronic Remittance Advices (ERAs) from testing. MACs and CEDI will provide information to

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the testers on who to contact for testing questions. There may be separate contacts for front end questions and remittance questions.

- MACs will post an announcement about the testing to their websites.

Additional Information

The official instruction, CR 8602, issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1352OTN.pdf on the CMS website.

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at **1.866.590.6703** and choose Option 1.

ICD-10 Information

SE1409 (Revised): Medicare Fee-For-Service (FFS) International Classification of Diseases, 10th Edition (ICD-10) Testing Approach

The Centers for Medicare & Medicaid Services (CMS) issued the following ***Special Edition Medicare Learning Network® (MLN) Matters*** article on February 19, 2014. A revision to this article was then issued on February 27, 2014. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2014-MLN-Matters-Articles.html

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Note: This article was revised on February 27, 2014, to add information about the second week of acknowledgement testing and to provide more details about end-to-end testing.

Provider Types Affected

This article is intended for all physicians, providers, and suppliers submitting claims to Medicare administrative contractors (MACs), including home health & hospice MACs (HH&H MACs), and durable medical equipment MACs (DME MACs)) for services provided to Medicare beneficiaries.

Provider Action Needed

For dates of service on and after October 1, 2014, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) are required to use the ICD-10 code sets in standard transactions adopted under HIPAA. The HIPAA standard health care claim transactions are among those for which ICD-10 codes must be used for dates of service on and after October 1, 2014. Be sure you are ready. This MLN Matters® Special Edition article is intended to convey the testing approach that CMS is taking for ICD-10 implementation.

Background

The implementation of International Classification of Diseases, 10th Edition (ICD-10) represents a significant code set change that impacts the entire health care community. As the ICD-10 implementation date of October 1, 2014, approaches, CMS is taking a comprehensive four-pronged approach to preparedness and testing to ensure that CMS as well as the Medicare Fee-For-Service (FFS) provider community is ready.

When “you” is used in this publication, we are referring to the FFS provider community.

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The four-pronged approach includes:

- CMS internal testing of its claims processing systems;
- Provider-initiated Beta testing tools;
- Acknowledgement testing; and
- End-to-end testing.

Each approach is discussed in more detail below

CMS Internal Testing of Its Claims Processing Systems

CMS has a very mature and rigorous testing program for its Medicare FFS claims processing systems that supports the implementation of four quarterly releases per year. Each release is supported by a three-tiered and time-sensitive testing methodology:

- Alpha testing is performed by each FFS claims processing system maintainer for 4 weeks;
- Beta testing is performed by a separate Integration Contractor for 8 weeks; and
- Acceptance testing is performed by each MAC for 4 weeks to ensure that local coverage requirements are met and the systems are functioning as expected.

CMS began installing and testing system changes to support ICD-10 in 2011. As of October 1, 2013, all Medicare FFS claims processing systems were ready for ICD-10 implementation. CMS continues to test its ICD-10 software changes with each quarterly release.

Provider-Initiated Beta Testing Tools

To help you prepare for ICD-10, CMS recommends that you leverage the variety of Beta versions of its software that include ICD-10 codes as well as National Coverage Determination (NCD) code crosswalks to test the readiness of your own systems. The following testing tools are available for download:

- NCDs converted from International Classification of Diseases, 9th Edition (ICD-9) to ICD-10 located at http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html
- The ICD-10 Medicare Severity-Diagnosis Related Groups (MS-DRGs) conversion project (along with payment logic and software replicating the current MS-DRGs), which used the General Equivalence Mappings to convert ICD-9 codes to International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10-CM) codes, located at http://cms.hhs.gov/Medicare/Coding/ICD10/ICD-10-MS-DRG-Conversion-Project.html on the CMS website. On this Web page, you can also find current versions of the ICD-10-CM MS-DRG Grouper, Medicare Code Editor (available from National Technical Information Service), and MS-DRG Definitions Manual that will allow you to analyze any payment impact from the conversion of the MS-DRGs from ICD-9-CM to ICD-10-CM codes and to compare the same version in both ICD-9-CM and ICD-10-CM; and
- A pilot version of the October 2013 Integrated Outpatient Code Editor (IOCE) that utilizes ICD-10-CM located at http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/Downloads/ICD-10-IOCE-Code-Lists.pdf on the CMS website. The final version of the IOCE that utilizes ICD-10-CM is scheduled for release in August 2014.

Crosswalks for Local Coverage Determinations (LCDs) will be available in April 2014.

If you will not be able to complete the necessary systems changes to submit claims with ICD-10 codes by October 1, 2014, you should investigate downloading the free billing software that CMS offers from their MACs. The software has been updated to

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support ICD-10 codes and requires an internet connection. This billing software only works for submitting fee-for-service claims to Medicare. Alternatively, many MACs offer provider internet portals, and some MACs offer a subset of these portals that you can register for to ensure that you have the flexibility to submit professional claims this way as a contingency.

Acknowledgement Testing

CMS will offer ICD-10 acknowledgement testing from March 3–7, 2014. This testing will allow all providers, billing companies, and clearinghouses the opportunity to determine whether CMS will be able to accept their claims with ICD-10 codes. While test claims will not be adjudicated, the MACs will return an acknowledgment to the submitter (a 277A) that confirms whether the submitted test claims were accepted or rejected. For more information about acknowledgement testing, refer to the information on your MAC's website.

Note from CGS: For more information about the ICD-10 testing week, refer to the "ICD-10-CM/PCS" Web page at http://www.cgsmedicare.com/parta/claims/ICD-10.html on the CGS website.

CMS plans to offer a second week of acknowledgement testing in early May 2014.

End-to-End Testing

In late July 2014, CMS will offer end-to-end testing to a small sample group of providers.

End-to-end testing includes the submission of test claims to CMS with ICD-10 codes and the provider's receipt of a Remittance Advice (RA) that explains the adjudication of the claims. The goal of this testing is to demonstrate that:

- Providers or submitters are able to successfully submit claims containing ICD-10 codes to the Medicare FFS claims systems;
- CMS software changes made to support ICD-10 result in appropriately adjudicated claims (based on the pricing data used for testing purposes); and
- Accurate RAs are produced.

The sample will be selected from providers, suppliers, and other submitters who volunteer to participate. Information about the volunteer registration will be available in March 2014. Over 500 volunteer submitters will be selected nationwide to participate in the end-to-end testing. The small sample group of participants will be selected to represent a broad cross-section of provider types, claims types, and submitter types.

Additional details about the end-to-end testing process will be disseminated at a later date in a separate MLN Matters® article.

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at **1.866.590.6703** and choose Option 1.

Medical Review Information

Immediate Suspension of Edits for Recovery Audit Prepayment Reviews, Including Outpatient Therapy

Effective February 28, 2014, there are two important changes regarding Recovery Audit Prepayment Reviews, including reviews for outpatient therapy. CGS, and other Medicare Administrative Contractors (MACs), will:

- No longer issue Additional Documentation Requests (ADRs) related to Recovery Audit Prepayment Reviews, including outpatient therapy, and

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- Suspend ALL edits related to Recovery Audit Prepayment Reviews, including outpatient therapy.

These changes are being made based on the current Recovery Audit procurement process. It is vital that the Centers for Medicare & Medicaid Services (CMS) ensure the smooth transition of workload in order to guarantee minimal disruption to the provider community. The last day that Recovery Auditors will send ADRs and Semi-Automated Notification Letters to providers is February 21, 2014.

CGS will process therapy claims in accordance with established guidelines.

For further information, refer to the following resources:

- CMS MLN Matters article MM8407, "Therapy Cap Values for Calendar Year (CY) 2014" - http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8407.pdf
- CMS Therapy Services Web page - http://www.cms.gov/Medicare/Billing/TherapyServices/index.html

Remittance Advice Information

MM8485: Reporting Principal and Interest Amounts When Refunding Previously Recouped Money on the Remittance Advice (RA)

The Centers for Medicare & Medicaid Services (CMS) has issued the following ***Medicare Learning Network® (MLN) Matters*** article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2014-MLN-Matters-Articles.html

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Effective Date: July 1, 2014
Implementation Date: July 7, 2014

Provider Types Affected

This MLN Matters® article is intended for physicians and other providers submitting claims to Medicare administrative contractors (MACs), including home health & hospice (HH&H) MACs for services to Medicare beneficiaries.

Provider Action Needed

This article is based on CR 8485 which informs MACs about changes necessary to create a new process that insures refunded principal and associated interest amounts can be reported separately on remittance advices and that claim identifiers are used to identify the appropriate claim for which those amounts apply. Make sure that your billing staffs are aware of these changes.

Background

CMS was advised that the current practice of reporting principal and interest amounts for all related claims on the Remittance Advice (RA) as one lump sum amount was creating problems for the provider community since it was not conducive to the proper posting of payments. CR 8485 instructs the MACs on how to report refunded principal and interest amounts separately and how to use claim identifiers to indicate the appropriate claim for those amounts. Providers should see these changes appear on RAs created after CR 8485 is implemented on July 7, 2014.

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Step-by-step instructions on how refunds with interest on previously recouped money are handled (including step(s) required by providers), as well as an example of reporting for the new Refund PLB Codes, are found in Attachment 1 to this CR.

Additional Information

The official instruction, CR 8485 issued to your MAC regarding this change is available at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1342OTN.pdf on the CMS website.

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at **1.866.590.6703** and choose Option 1.

Therapy Information

MM8556: Therapy Modifier Consistency Edits

The Centers for Medicare & Medicaid Services (CMS) has issued the following ***Medicare Learning Network® (MLN) Matters*** article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2014-MLN-Matters-Articles.html

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Implementation Date: July 7, 2014

What You Should Know

This MLN Matters® article is intended for physicians, providers and suppliers submitting claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries.

Provider Action Needed

This article is based on CR 8556, which creates edits in Original Medicare claims processing systems to ensure that certain 'always therapy' evaluation and reevaluation codes are reported with the correct modifier. It also makes several clarifications of details in the Medicare Claims Processing Manual, Chapter 5 - Part B Outpatient Rehabilitation and Comprehensive Outpatient Rehabilitation Facility (CORF) Services.

CR 8556 contains no new policy. It updates Medicare systems and manuals to better reflect current published policies. Make sure that your billing staffs are aware of these updates.

Background

Longstanding Original Medicare billing instructions require reporting of discipline specific outpatient rehabilitation modifiers. All claims for therapy service Healthcare Common Procedure Coding System (HCPCS) codes must report a modifier that indicates the discipline of the plan of care under which the services are provided.

Through analysis of Original Medicare claims data, the CMS has identified cases where claims for discipline specific evaluation codes have reported the modifier corresponding to another discipline. For example, occupational therapy evaluations have been billed and paid while reporting a GP modifier (Services delivered under an outpatient physical therapy plan of care.). When information on a claim is clearly self-contradictory, as in this example, the claim should be returned to the provider for correction. The business requirements in CR 8556 create edits to do this, effective for dates of service July 1, 2014, and after.

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In addition, CR 8556 updates Medicare Claims Processing Manual, Chapter 5 - Part B Outpatient Rehabilitation and Comprehensive Outpatient Rehabilitation Facility (CORF) Services to reflect recent payment regulations. The Fiscal Year (FY) 2014 inpatient hospital final rule contained a policy regarding rebilling of Part B services when an inpatient stay is denied as not reasonable and necessary. This policy is now included in Section 40.8 of Chapter 5 of the Medicare Claims Processing Manual. Specifically, it states that if a beneficiary receives therapy services during an inpatient hospital stay which was denied because the stay was not medically necessary, the therapy services may be rebilled under Medicare Part B coverage. If the therapy would have been reasonable and necessary as hospital outpatient services, and provided the beneficiary has Part B entitlement, the services can be billed using Type of Bill 012x. All payment and billing requirements for outpatient therapy (including therapy caps, functional reporting and other instructions in this chapter) apply to these claims.

Additional Information

The official instruction, CR 8556, issued to your MAC regarding this change, may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2868CP.pdf on the CMS website.

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at **1.866.590.6703** and choose Option 1.

Helpful Information

Contact Information for CGS Part A

To contact a CGS Customer Service Representative, call the CGS Provider Contact Center at **1.866.590.6703** and choose Option 1. For additional contact information, please access the Kentucky & Ohio Part A "Contact Information" Web page at http://www.cgsmedicare.com/parta/help/contact_info.html for information about the myCGS Web portal, the Interactive Voice Response (IVR) system, as well as telephone numbers, fax numbers, and mailing addresses for other CGS departments.

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